



Joints in Motion Medical, LLC  
1343 E. Wisconsin Avenue, #112  
Pewaukee, WI 53072

Phone: (262) 547-4276  
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## Patient Financial Disclosure

**Patient Name:** \_\_\_\_\_

Please  
initial  
each line

**Equipment issued:** \_\_\_\_\_

- \_\_\_\_\_ 1. I understand that billing for equipment will begin the day I receive it, on the day of my discharge from the hospital, or on the date I begin using the equipment as confirmed during my initial patient follow-up call, whichever is latest, and will continue until the day I call and report I am no longer using it.
- \_\_\_\_\_ 2. I understand that even though my Doctor has prescribed this equipment and prior authorization may have been obtained, my insurance company makes an independent determination as to whether they feel the equipment is "medically necessary" at the time the claim is submitted. My insurance coverage for this equipment may be dependent on my diagnosis and/or surgical procedure, and my insurance company may impose limits on the length of time that they will pay for this equipment.
- \_\_\_\_\_ 3. I understand that out-of-network benefits may apply if Joints In Motion Medical or the companies they represent are not considered an in-network provider with my insurance plan.
- \_\_\_\_\_ 4. I understand that I am responsible to pay for any charges related to the use of this equipment that my insurance company does not pay in full. This includes any applicable deductibles and co-payments if the equipment is determined to be "medically necessary", as well as charges due if my insurance company denies payment. If I assert that my injury is work related, I understand that if the workers' compensation insurance denies my claim as not a work related injury, I will be responsible for the charges accrued.
- \_\_\_\_\_ 5. I understand that if I agree to a patient pay rate as documented on the Patient Agreement and Assignment of Benefits form, Joints In Motion Medical will decline to submit a claim to my insurance for that item. Discounted patient pay rates will not be prorated.
- \_\_\_\_\_ 6. I understand that I have the right to refuse delivery of this equipment, even though my Doctor has prescribed it for me.
- \_\_\_\_\_ 7. I understand that in the event that this equipment is not covered by my insurance, Joints In Motion Medical offers affordable installment plans.

☐ **SUBCONTRACTING DISCLOSURE:** In order to minimize your out-of-pocket cost, JIMM will partner with \_\_\_\_\_, a preferred/in-network provider with your insurance plan. They will submit the claim to your insurance company for items provided. They can be reached at \_\_\_\_\_ - \_\_\_\_\_ with any questions regarding your insurance claim for these items. If you have any questions about how to use the equipment, or require service, please call JIMM at 866-546-4276.

\_\_\_\_\_  
Patient/Responsible Party Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship of Responsible Party to Patient

05/2013