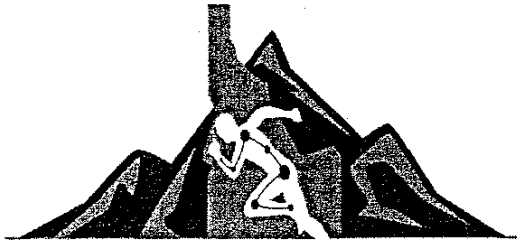

Ortholdaho

Aaron L. Altenburg, M.D.
Benjamin Blair, M.D., A.B.O.S
S. Jeff Bray, D. P. M., F.A.C.F.A.S
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Richard A. Wathne, M.D., F.A.C.S., A.B.O.S
Matt McKinlay, PA-C
Justin C. Pool, P.A.-C
Boe Simmons, P.A.-C

Welcome to Ortholdaho; Aaron J. Altenburg, M.D., Benjamin Blair, M.D., S. Jeff Bray, D.P.M., Anthony E. Joseph, M.D. and Richard A. Wathne, M.D., Our staff looks forward to assisting you and making your visit with our organization a pleasant one.

At your initial visit, we request a minimum payment of $50.00. If you are covered by insurance, we are required to collect any applicable co-pays at each visit. We accept cash, check or debit/credit card. If you do not have insurance coverage, we request a minimum payment of $200.00 upon your initial visit. In addition, you will be asked to make arrangements to pay for future visits at the time of service. Monthly payments are required to keep an account current, regardless of insurance coverage.

All accounts 90 days past due will be assessed a **FINANCE CHARGE** of **1.5%** per month.

I authorize Ortholdaho to release any information required to process my claims and any that may be necessary in the course of examination and treatment. I assign my insurance proceeds and/or health benefits to Ortholdaho and authorize my insurance company and/or benefits administrator to pay these assigned proceed/benefits directly to Ortholdaho. I give my informed consent for physicians of Ortholdaho and medically licensed staff members to perform necessary treatment for me or my minor child. I understand that I am financially responsible for all charges whether or not paid by my insurance and/or benefits administrator. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and other pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

PLEASE READ AND SIGN THE FOLLOWING:
I directly assign all medical/surgical benefits to Ortholdaho and understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize Ortholdaho to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

I, the undersigned, acknowledge and agree that I have read a copy of Ortholdaho Financial Policy.

_____Date_____

Patient/lLegal Guardian Signature