

CENTER FOR ORTHOPEDIC CARE

PATIENT FINANCIAL POLICY

The Center for Orthopedic Care is happy to have been chosen to provide you with your orthopedic care. As a courtesy to our patient, we offer full-service billing to our patients. In return we ask that you adhere to the following guidelines. We thank you in advance for your anticipated cooperation.

PATIENTS WITHOUT INSURANCE

Unless prior arrangements have been made with our billing office, payment is required at the time of service. We accept payments of cash, check, Visa, and MasterCard. Bank Check Cards are accepted if they bear the Visa or MasterCard Logo.

PATIENTS WITH INSURANCE COVERAGE

Referrals and co-payments are your responsibility and are required at the time of service. If you do not have the required referral with you, we will have to reschedule your appointment. If our office does not participate with your insurance company, we will send a statement to them on your behalf. Be advised that if we do not receive payment within 45 days you will be expected to pay the balance. If we later receive payment from your insurance company we will refund any overpayment to you.

PATIENTS WITH WORKERS COMPENSATION, MOTOR VEHICLE ACCIDENT INSURANCE OR LIABILITY COVERAGE

At the time of your visit, you **must** provide us with the name of your insurance carrier, their phone number, the date of the accident, your policy number and the name of your adjustor. Failure to provide all the required information will result in the statement being sent directly to you. If you are treating for an accident case, our office does not bill your private health insurance under any circumstances. **IF YOU HAVE BEEN REFERED BY AN ATTORNEY** the visit must have been pre-authorized and payment arrangements made in advance. **We do not accept letters of protection.**

FOR ALL PATIENTS

Each insurance company and each employer furnishing insurance coverage has a schedule for payment of your service that may differ from that of another plan. Please be aware that some services may not be covered or considered by your insurance company to be reasonable and necessary and you will be responsible for these amounts when our contract allows us to bill you for them. Additionally, if your insurance company has not paid for your service within 45 days of our claim submission, you may be responsible for the balance.

Our office has several guidelines to follow when billing your insurance. Any delay due to invalid information provided by you will result in the bill becoming your responsibility. Whenever you have a question about your insurance coverage, it is always best to contact the customer service representative at the number provided on your insurance card.

COLLECTION POLICY

Any balance remaining after your insurance has paid their part of the covered portion will be due upon receipt of a bill (e.g. Coinsurance, Deductible, non-covered, etc.). Our billing office is always available to help you with any questions and or payment arrangements. If you need to make special arrangements, it is your responsibility to contact the billing office before your account is sent to an outside agency. Once made in writing, agreements are binding. We consider payment by the patient for services rendered to be an important part of the patient's role in the patient/physician relationship. Prompt payment for services rendered is expected and failure to comply or respond to repeated communications from our office may result in discharge from our practice and/or involvement of an outside collection agency. Once an account has been referred to an outside agency, prior balances must be resolved before being seen by the physician.

By signing below, you agree to the terms of this policy. Additionally, you agree to allow The Center for Orthopedic Care to provide to your insurance company or any of its agents any medical information requested in order to process payment of your claim.

If you are signing on behalf of a minor, you are agreeing to be responsible for payments on this account regardless of parental custody. If more than one party has insurance coverage for the minor, please be certain to provide the information to us so that we may file your secondary claims.

“I understand and agree to the terms of this policy and will be responsible for any balances due as indicated.”

Patient Name, Printed

Patient Signature

Date

Name of Responsible Party
(If other than patient)

Signature of Responsible Party

Date