CENTER FOR JOINT SURGERY AND SPORTS MEDICINE FINANCIAL POLICY

Center for Joint Surgery and Sports Medicine is dedicated to providing our patients with the best possible care and services while keeping the costs to you from increasing at an unreasonable rate.

INSURANCES:
We participate with several insurance companies. Please check with the Billing Dept. to see if we participate with your plan.

If we DO participate with your insurance company, all services performed in our office and at the hospital will be submitted to them, unless we have received prior notification of non-covered services. All co-pays and deductibles are the patient's responsibility.

CO-PAYS:
The patient is required to present an insurance card at each visit. All co-payments and past due patient balances are due and payable at the time of service. If co-payments are not paid, the patient will be billed a $25.00 processing fee.

REFERRALS:
If your insurance has designated a primary care physician (PCP), you are required to have an authorization from your PCP prior to your visit. You may use the office telephone to obtain the authorization. If this authorization is not provided on the day of service, you will be asked to either reschedule your appointment or sign a waiver. We are notifying you of this policy in writing regardless of our agreement with your insurance company.

If we DO NOT participate with your insurance company, this means that we will bill your insurance company as a courtesy to the patient; however, in most cases since we do not participate with your insurance, you will receive the check and must mail the payment to us directly. We do not accept payment from them as payment in full for the services performed. All insurance carriers have a schedule of fees from which they will pay; however, the doctor's fees may be more than what the insurance company shows on their schedule. Therefore, any balance not covered by the insurance company becomes the responsibility of the patient. Payment for office visits <u>ARE</u> due at the time of service.

*IT is important for you to understand that your health insurance coverage is an agreement between **<u>YOU</u>** and **<u>YOUR INSURANCE COMPANY</u>** and your doctor's bill for the services provided to you is an agreement between you and your doctor.*

PAYMENT FOR SERVICES PERFORMED:
Our office accepts cash, checks, Visa, MasterCard, and Discover. All payments are expected at the time of service and any outstanding balances are due within 30 days, unless prior arrangements have been made with the Billing Department. A $15.00 administrative fee will be charged for all balances not paid within 30 days. All balances that reach 90 days past due will be sent to a collection agency. Should your account be sent to a collection agency, you will be financially responsible for all collection fees and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.

Payment in full of any past due balance is expected prior to being seen in our office in the future. In addition, payment in full will be expected at the time of service for any future services.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY CENTER FOR JOINT SURGERY AND SPORTS MEDICINE AND I AGREE TO THE TERMS OF THIS FINANCIAL POLICY. I ALSO UNDERSTAND AND AGREE THAT THE TERMS OF THE FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

OVER

CENTER FOR JOINT SURGERY AND SPORTS MEDICINE FINANCIAL POLICY

We must emphasize that as physicians, our relationship is with you, NOT your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from the dates services are rendered. Therefore, it is often necessary for you to inquire and explore your benefits with your insurance carrier. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

We are committed to providing you with the best care possible. If you have medical insurance, we are pleased to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and you're understanding of our payment policy.

Checks returned by your bank are subject to a $25.00 processing fee. **A CHARGE OF $25.00 WILL BE MADE FOR NO SHOW APPOINTMENTS. IT WILL BE THE PATIENT'S RESPONSIBILITY TO RESCHEDULE.**

PATIENT REFUNDS:
The following criteria MUST be met prior to issuing a refund: The patient has not been seen in the office for 90 days, there is no outstanding insurance claims on the patient's account; and there are no outstanding patient balances on the account.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that your insurance is a contract between you, your employer (possibly), and the insurance company. We are not party to that contract except where we are contracted as preferred providers.

WORKERS COMPENSATION CASES AND AUTOMOBILE ACCIDENTS:
In the case of a workmen's compensation injury or automobile accident, you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier prior to your visit. If this information is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service. If and when a claim is denied we will expect payment from the patient within 30 days of receipt of our bill. If the patient has other insurance options, Center for Joint Surgery and Sports Medicine will cooperate whenever possible in assisting the patient in his/her efforts to be reimbursed from the source.

In order for Center for Joint Surgery and Sports Medicine to provide the quality of care it offers, you must be willing to do your share in helping us to help you receive insurance benefits for which you are fully entitled.

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Patients Signature (SEAL) Date
Or Parent/Legal Guardian (SEAL)

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Please Print Name

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____________________________________, have received the Notice of Privacy Practices from the Center for Joint Surgery and Sports Medicine.

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Witness Date