Orthopedics Northwest – FINANCIAL POLICY

Please read our financial policy. Not only are we committed to providing excellent orthopedic care to you, we are committed to providing you with information so you can make informed decisions regarding your financial matters.

- We accept payment by cash, check, VISA, MasterCard and Discover
- **Co-pays are collected upon appointment check-in.** We will bill you for deductibles and co-insurance when we receive payment from your insurance.
- A charge of $25.00 for returned checks will be assessed.
- Private Pay (no insurance) - $100 deposit is expected at the first appointment, and $25.00 for later appointments when there is no arrangements made with the Billing Office prior to receiving services.
- **Surgery Payment Deposit: A $500 deposit is required and will be collected at or prior to your preoperative appointment (excludes WC, Medicare and Medicaid).**
- Our Billing Office is available during regular business hours to discuss payment options should you desire this information and may assist you if you need to set up a budget payment plan.
- We reserve the right to send all accounts with balance over 60 days old to an outside Collection Agency. All accounts sent to collections may be charged a $25.00 processing fee. You may be responsible for all reasonable collections and attorney costs incurred. You agree that we and/or our business associates can call/leave messages at your home or work regarding your account.
- **INSURANCE and PHOTO ID - <u>Please bring your insurance card(s) and photo ID to every visit.</u>**
  It is your responsibility to verify coverage of specialist services prior to being seen at our office. As a courtesy, we will bill your primary and secondary insurance carriers based on information you provide on your patient registration forms. If you are unable to provide a valid photo ID, Orthopedics Northwest may not bill your insurance company, and you may have to pay for your visit at the time of service. We do not remit payment within 45 days from the date of service, your personal payment of the bill in full is expected, unless arrangements have been made with our Billing Office. If your insurance pays after we have received your payment, you will receive a timely refund.
- **WORKERS' COMPENSATION -** If your injury is work related, you need to tell us before being seen by the doctor. You are required to notify your employer and initiate a work comp claim. Please provide us with complete employer information, claim information (e.g., work comp insurance carrier, claim number), and the details surrounding your injury.
  We require you to provide us with your regular health insurance in the event that your work comp carrier denies your claim. If you do not have health insurance and your claim is denied, you will be responsible for your balance.
- **MOTOR VEHICLE ACCIDENTS (MVA) / THIRD PARTY LIABILITY -** $100.00 deposit is due at your first MVA/other accident related visit. We will attempt to file claims with the motor vehicle or third party insurance company that you designate. If the claims are denied, or a protracted lawsuit is involved, the patient is responsible to pay the account balance in full. We will bill your health insurance for balance left after your personal injury protection (PIP) is exhausted.
- **COLLECTION STATUS PATIENTS -** If your account is in collections status, we require $100.00 at each office visit which will be applied to your account balance. Your current account balance must be paid in full before another surgery will be scheduled.
- **INJECTIONS / ASPIRATIONS -** All injections / aspirations are classified as surgical procedures. Your insurance may require you to pay a percentage or put the cost towards your deductible for injections/aspirations.
- **REFERRAL POLICY -** I acknowledge I have contacted my insurance carrier and have a referral in place at the time of my visit or no referral is required by my insurance.
- **CANCELLATION POLICY -** For non-cancelled appointments without at least a notice of one (1) day, a $25.00 fee may be assessed. For more than three (3) non- cancellations in a calendar year, the patient relationship with the physician may be terminated in order for the patient to see care from another physician.
- **MINORS -** Both Parents are responsible for services of a minor child and we will bill the adult signer of this form for paying the medical expenses.

I have read and understand the terms of this Financial Policy. I am responsible for the payment of my account within the limits for this Policy regardless of insurance coverage. I agree to pay all costs and reasonable attorney fees if suit is instituted to collect monies owed by me, including interest charges, processing fees that may be assessed by any collection agency retained to pursue this matter.

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Print Patient Name **Date**

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Patient or Legal Guardian Signature