GENERAL FINANCIAL POLICY

The Bone and Joint Care Center participates with many insurance plans. As a participating provider, we will accept the carrier's allowable amount. Patients are responsible for co-payments, co-insurance amounts and/or deductibles, as well as payment for services not normally covered by the carrier. Co-pays will be collected at each visit. If copays and past due balances are not paid, your appointment may be rescheduled, and payment must be made prior to the next scheduled visit. If you are insured under a plan that we do not participate with and you choose to receive your care with us, we can make arrangements to courtesy bill the carrier, however, the patient is responsible for the bill in its entirety.

Please remember that your insurance plan is a contract between you and your insurance carrier. This contract usually requires a shared responsibility between the insurer and the patient in payment for our services. While we will act on your behalf to obtain payment for our services, once we have exhausted all efforts, the patient is responsible for the balance due. Our billing department can develop a payment plan to suit your needs to ensure that your account remains in good standing, should this become necessary. Our office also accepts Visa, Mastercard and Discover in addition to cash and personal checks as methods of payment.

REFERRALS

If your insurance requires a referral form from your PCP for your visit with our practice, the referral must be obtained by the patient and presented to us at the time of the visit. If a referral from your PCP is not present at the time of the visit, the visit will be rescheduled to allow time to contact your PCP and arrange for a referral.

SECONDARY INSURANCES

We strive to provide complete billing service to our patients. We will submit your secondary insurance claim a maximum of two times. After two submissions without a response, the balance will be billed to the patient. Our office will not file to tertiary insurances, but will provide you the necessary documents to do so upon request.

SELF-PAY POLICY

Patients without insurance coverage who wish to receive care with us must establish a payment plan with our billing department prior to receiving services or immediately after receiving emergency services.

COLLECTION ACCOUNTS

Our office will make every effort to communicate with you about your account and will present reasonable options for payment. In the event that we involve a third party for collection of an account, we will add a fee of 25% of the total balance to your account for administrative costs, a minimum of $25. You will not be permitted to return for a new episode of care until you have satisfied the old debt.

CHECKS RETURNED FOR INSUFFICIENT FUNDS

If we receive a returned check for insufficient funds, we will immediately reverse the payment on your account, thereby adding the amount back onto your account and we will also charge a $30.00 fee to your account.

DISABILITY INSURANCE FORM COMPLETION

Our office will complete your disability insurance claim forms. The fee for each form is $20 (cash or check) and must be paid in advance of or at the time you receive your completed form. If you have asked us to mail your form directly to your insurance company, you will be required to pay the $20 (cash or check) fee when you drop the form off at our offices.

I have read and understand the Financial Policy as outlined above, and I agree to abide by its guidelines:

Patient/Guarantor Signature _____ Date _____

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

My signature below indicates that:

- I assign and authorize any insurance company, health plan, employer, governmental agency, or other third-party payer of medical benefits to make payment directly to Bone & Joint Care Center and/or Keystone Orthopaedic Specialists for all benefits payable thereunder.
- Based on the services provided to me by Bone & Joint Care Center and/or Keystone Orthopaedic Specialists, I assign to Bone & Joint Care Center and/or Keystone Orthopaedic Specialists any and all rights to receive such payments.
- I understand I have a personal financial responsibility to Bone & Joint Care Center and/or Keystone Orthopaedic Specialists for services not covered by a third party for which I am legally obligated.

PRINT Patient Name: _____

Signature of Patient or Authorized Representative:_____

Date: _____