Orthopaedic Specialists

FINANCIAL POLICY

Patient ID#_____

Thank you for choosing ***OAA Orthopaedic Specialists*** as your orthopaedic specialty healthcare provider. We are committed to providing you and your family with the best available medical care. In our ongoing process to make sure that all your medical needs are met, our staff will be available to discuss our fees and this policy with you. The Services you have elected to participate in means that you accept a financial responsibility on your part.

We ask that all responsible parties read and sign our financial policy as well as complete the patient information forms prior to seeing the physician.

Payments for all services will be due at the time services are rendered. In order to serve you better, we accept cash, check, Visa, Discover and MasterCard. As a courtesy to you, we will verify your coverage and bill your insurance carrier on your behalf; however, you are ultimately responsible for the entire bill. The only exception to patient responsibility for payment is for an appointment for employer requested work performance screenings.

As the responsible party, please understand:

1. Your insurance policy is a contract between you, your employer (if applicable), and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance and “usual and customary” charge. As your medical provider, we will only supply factual information to facilitate claim processing.
2. If your insurance requires a referral for you to see an OAA Orthopaedic Specialists provider, it is your responsibility to provide our office with the referral. If your insurance company denies payment due to no referral, you, the patient, agree to pay OAA Orthopaedic Specialists in full for any charges incurred during your visit.
3. Fees for services, which include unpaid balances, deductibles, co-payments and in some cases coinsurance, are due at the time of service. Returned checks and unpaid balances may be subject to collection placement and collection fees. Co- Payments for additional services such as radiology, in office procedures, and/or injections may be billed by your insurance company later. This is the patient’s responsibility.
4. All charges are your responsibility whether your insurance company pays or does not pay. If your insurance carrier does not remit payment within sixty days, the balance may be due in full. If any payment is made directly to you for services billed by OAA Orthopaedic Specialists, you recognize an obligation to promptly remit payment to OAA Orthopaedic Specialists.
5. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by OAA Orthopaedic Specialists, I will be responsible for all costs of collecting monies owed, including collection agency fees. Billing statements will not be generated for balances of $10 or less. These patient balances can be made via patient portal or in person at the check in desk.

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6. The above does not apply for those patients that are considered Workers' Compensation. However, be advised that as a compensation patient you may be held responsible for charges if your claim is denied or not paid or determined not to be work related.
7. Our practice utilizes the services of Assistant Surgeons/Physician Assistants for medical services including surgical procedures. As with the other professional services, we will bill your insurance for these services; however, should your insurance not cover the charges, you may be held ultimately responsible.
8. The completion of disability and/or FMLA forms are not billable/reimbursable by insurance carriers, therefore fees are your responsibility for payment. OAA Orthopaedic Specialists fees related to completion of these documents is $10.00 which is expected to be paid upon presentation of forms for completion. Please allow 10 to 14 business days for completion of these forms.
9. If you need to cancel your scheduled appointment, OAA asks that you contact our office at least 24 hours in advance. Please review the attendance and no-show policy. OAA reserves the right to charge a $50 fee for any appointment not cancelled within 24 hours.

Patient Attendance Policy

OAA Orthopeadic Specialists mission is to provide our patients with the highest quality of care for your musculoskeletal needs. The success of your individual treatment plan depends on consistent attendance to your scheduled appointments. Our team does our best to accommodate all our patients scheduling needs.

Last minute cancellations along with no show appointments, lower your chances of meeting and maintaining your goals for care and hinder our ability to accommodate the scheduling needs of all our patients. We kindly ask that you allow 24-hour notice for any cancelled appointments.

Also, if three (3) appointments are missed without prior notice, we will require you to submit a formal letter to your physician explaining why you have missed your appointments. This letter will be reviewed by the clinical departments and physician prior to scheduling any additional appointments.

Our staff will make every attempt to accommodate any rescheduling needs. Thank you for your cooperation in this matter.

10. Patients with a balance of $500 or greater cannot schedule surgery until they meet with a financial assistant and arrange a re- payment plan. Self-pay surgeries will be discussed with the billing specialist and patient will be responsible for paying half the surgery cost prior to surgery.

We understand that financial problems may affect timely payment, so we encourage you to communicate any such problems to us, so that we may assist you in keeping your account in good standing. Our financial counselor is available to assist you or answer any questions you may have.

INSURANCE RELEASE INFORMATION

I HEREBY AUTHORIZE THE OFFICE OF OAA ORTHOPAEDIC SPECIALISTS TO RELEASE TO MY INSURANCE COMPANY ANY NECESSARY INFORMATION NEEDED TO FILE AND EXPEDITE PAYMENT ON MY CLAIM. I FURTHER ASSIGN ANY BENEFITS PAYABLE ON MY BEHALF TO OAA ORTHOPAEDIC SPECIALISTS. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER.

I UNDERSTAND THE ABOVE INFORMATION AND WILL BE RESPONSIBLE FOR THE PATIENT LISTED BELOW

Printed Name of Patient:_____ DOB:_____

_____ _____

Signature of Patient or Responsible Party Date

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