

APPALACHIAN ORTHOPEDIC CENTER FINANCIAL POLICY

Appalachian Orthopedic Center LTD. is dedicated to providing our patients with the best possible care, while keeping the costs to you from increasing at an unreasonable rate. We ask your help by understanding and cooperation with our 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. 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.

INSURANCES:

We participate with many insurance companies. Please check with any front office staff to see if we participate with your insurance plan.

If we DO participate with your insurance company, all services performed in our office, hospital or surgery center will be submitted, unless we have received prior notification of non-covered services. All co-pays and deductibles are your responsibility and due at the time of service. **For elective surgery, deductibles and co-insurances will be required prior to the surgery date.**

If we DO NOT participate with your insurance company, this means that we will bill your insurance company as a courtesy. 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 will pay. Any balance not covered by the insurance company becomes your responsibility.

For secondary insurances, we will submit your secondary insurance claim a maximum of two times. After two submissions, the balance will be billed to you.

CO-PAYS AND OUTSTANDING BALANCES:

All co-payments are due at the time of service. If co-payments are not paid at the time of service a \$10.00 billing charge will be added to your account, unless other arrangements were made with the billing office staff. All outstanding balances on accounts are due at the time of service.

REFERRALS:

If your insurance has referral requirements, you are required to have prior authorization or a referral from your Primary Care Physician (PCP) prior to your visit. You may use the office telephone to obtain authorization or a referral. If this authorization or referral is not provided the day of service, you may be asked to either reschedule your appointment or pay at the time of service.

DISABILITY INSURANCE FORM COMPLETION:

Our office will complete your disability insurance claim forms. The fee for each form is \$15 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 \$15 fee when you drop the form off at our office. **PLEASE ALLOW 5-7 DAYS FOR COMPLETION OF YOUR DISABILITY FORMS.**

CHECKS RETURNED FOR INSUFFICIENT FUNDS:

If we receive a returned check for insufficient funds, we will immediately reverse the payment on your account and will also charge a \$30 fee to your account.

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 a bill goes unpaid without contacting the billing department to discuss payment options, the account may be turned over to collections. If your account is sent to a collection agency, a collection charge will be applied.

SELF-PAY POLICY:

Payment is expected at the time of service. Prompt pay discounts may be available, please check with practice staff for details.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY APPALACHIAN ORTHOPEDIC CENTER, LTD 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.

Signature of Patient/Guardian

Date