

## **Milwaukee Orthopaedic Group, Ltd. -- Financial Policy -- September 1, 2005**

### **Statement of Policy**

It is very important for you to have a clear understanding of the financial responsibilities that are entered into when you obtain the services of the physicians and ancillary staff associated with our facility.

All accounts are payable within 45 days after initial billing regardless of third party responsibility. Special credit terms and arrangements may be extended to patients as a courtesy and will be based on demonstrated financial need.

**You, the patient, are ultimately responsible for all services rendered.**

We will submit to your primary insurance carrier as a courtesy. Insurance is a contractual agreement between the patient and their insurance carrier. The services are provided to the patient and are the responsibility of the patient.

### **IF YOU HAVE INSURANCE COVERAGE AND ARE ASSIGNING HEALTH INSURANCE BENEFITS:**

We ask that you provide **accurate and complete information** for the submission of charges to the insurance carrier. It is very important to keep the insurance information current and we will ask to see your card each time you visit for services to verify the content of the insurance file for accuracy. The practice cannot be responsible for errors due to missing, incomplete or out of date information.

We will ask that you pay your co-pays, co-insurance and deductibles at the time of service if due. You must authorize your insurance carrier to pay us directly if payment is due from the insurance company. You will be billed for any portion of the services that the insurance carrier does not cover.

It is important that you verify our participation in your health plan before your initial visit. Failure to do so will result in your being personally responsible for the total bill. Your carrier has provided you with a listing of network participants, a website, or a number to call to verify physician participation.

### **IF YOU HAVE NO INSURANCE:**

It will be necessary to pay for your medical services during registration of your appointment. We will advise you of the anticipated costs of the visit. (\$200.00 Deposit) These deposits do not constitute full payment of services. Payment may be made initially by cash or credit card. If you have had an account with us previously we may accept a personal check for payment. You will be balance billed for any portion of the service that your initial payment does not cover. Monthly payments can be arranged with the billing office. If overpayment is received, a refund will be given.

## **WORKERS COMPENSATION, ACCIDENTAL INJURIES, LIABILITIES:**

If you are claiming workers compensation or filing claims to a liability carrier you still must obtain required personal health insurance referrals for all services provided to you. In the event that payment is denied by a workers compensation or liability carrier, we will file claims with your personal health insurance. If your claim is denied and your personal health carrier will not pay for services rendered, you will be required to pay your account. We will require consistent monthly payments. **THE PRACTICE WILL NOT WAIT FOR SETTLEMENT OR LITIGATION PROCEEDINGS FOR PAYMENT OF YOUR TREATMENT. YOU ARE RESPONSIBLE FOR PAYMENT.** New patients with personal injuries must be approved by the physician.

## **ELECTIVE SURGERY REQUIREMENTS**

Prior to scheduling elective surgical procedures you will meet with a scheduler to coordinate the surgery preference date, testing requirements, insurance authorizations and payment responsibilities. Payments may be requested for the deductible amounts, and the co-insurance amounts not paid by insurance. We can arrange monthly pre-payments in advance of the procedure to give you additional payment time.

## **COPAY REQUIREMENTS BY CONTRACT:**

COPAYS must be paid at the time of your appointment. Your insurance card will indicate if you have a COPAY requirement. If you are unsure, contact your insurance carrier to determine the amount required prior to your appointment.

**OUR PHYSICIAN MAY NOT SEE YOU IF YOU ARE UNABLE TO MEET YOUR COPAY REQUIREMENT.**

## **REFERRALS:**

Referrals may be a requirement of your particular insurance plan. If you need a referral for specialist services, you must make arrangements to have the referral sent to our office well in advance of your appointment.

**If we do not have the referral your appointment will be rescheduled until a referral can be obtained.**

**RETURNED CHECK FEE:** A service fee of \$30.00 will apply for check and credit card payments returned from the bank.

**COLLECTION AGENCY REFERRAL FEES:** A collection charge will be added to the amount due if an account is processed to a collection agency for non-payment. If litigation is required additional legal fees will be added to the account.

**MINORS:** Minors must be accompanied by a parent or legal guardian. If the parents are separated and both parents are legally responsible for minor child, provide complete information so we may bill both parents. The parent or guardian that accompanies the minor to the appointment will be held wholly responsible for payment of the services should any dispute over payment arise.

**NO SHOWS:** An appointment will be considered a no-show unless there is advance notice of cancellation. A patient with three no show appointments in one calendar year will be considered non-compliant. As a non-compliant patient, your physician may exercise his or her right to terminate the physician-patient relationship.

Cash, personal check, Visa and MasterCard accepted.

**YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE RECEIVED THIS FORM AND UNDERSTAND AND AGREE TO THE POLICIES.**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_