

Patient: Last Name _____ First _____ MI. _____



Our Financial Policy

Thank you for choosing Coastal Orthopaedics as your health care provider. We are committed to the success of your treatment. Please understand that paying your bill is a part of the process. It is important that you understand the following points:

- 1) Co-pays must be paid at the time of your visit. We accept cash, checks, money orders and credit card payments.
- 2) You will be assessed a fee of \$15 for reprocessing checks returned for insufficient funds.
- 3) You are primarily responsible for the charges incurred.
- 4) We will bill your insurance company, but only if we have all necessary information.
- 5) If your insurer requires a referral from your primary care physician, it is your responsibility to obtain one.
- 6) We reserve the right to reschedule your appointment unless a valid referral has been received, if applicable.
- 7) We will assist you with any pre-authorizations for surgeries.
- 8) If your insurance company fails to pay your bill within 60 days the bill will be transferred to you.
- 9) You are responsible for treatment, supplies, etc. which your insurance company deems "non-covered".
- 10) We accept Medicare, however a 20% co-pay is required unless you have secondary insurance.
- 11) We participate in many managed care plans and will comply with our contractual obligations.
- 12) If your injuries occurred as a result of an automobile accident we will bill **your** auto insurer and allow them to initiate coordination of benefits.
- 13) If you have retained an attorney, due to your accident, he/she may take your case on a contingency basis. We do not. We will **not** suspend billing until you receive a settlement.
- 14) We will complete all disability forms for you. A minimal fee of \$5.00 must be paid.
- 15) If you have no insurance, we have multiple payment options available including monthly billing of a credit card, prompt payment discount program, and a payment schedule agreement. It is very important that payments be mad consistently and timely.
- 16) Unless prior arrangements are made, your account will be turned over to a collection agency if no payments have been received as per your payment schedule agreement or for accounts 60 days in arrears.
- 17) Adult patients are responsible for full payment of their accounts.
- 18) Patients under the age of eighteen (18) will not be seen unless accompanied by a guardian or unless we receive a signed authorization from the guardian allowing the physician to provide medical treatment.

If you have any questions, please ask.

I have read the Financial Policy of Coastal Orthopaedics. My signature indicates that I understand and agree to comply with this policy.

Signature of Patient or Responsible Party (state relationship)

Date