JANSEN ORTHOPAEDIC CLINIC

PATIENT FINANCIAL POLICY:

Patient Name:_____ DOB:_____

Thank you for choosing **Jansen Orthopaedic Clinic** for your orthopaedic care. We are committed to the success of your medical treatment and care. Please understand that a mutual financial understanding is part of our relationship.

We sincerely hope that by sharing our financial expectations we will strengthen the physician-patient relationship and keep the lines of communication open. This financial policy helps us provide the quality care to our valued patients. If you have any questions or need clarification of the below policies, please feel free to contact our billing department at (574) 267-2663.

Payment is Due At the Time of Service:

- We accept cash, checks, debit and credit cards (Visa, Mastercard and Discover).
- All Co-payments, deductibles, co-insurance and fees for non-covered services are due at the time of service unless you have made payment arrangements prior to your appointment.

_____ Initials

- Insurance required co-payments are due at your appointment. If you arrive without your co-payment, we may ask you to reschedule.

_____ Initials

- If your co-payment is based on a percentage (example: 20% of the allowed payment) and you do not have a secondary policy, please be prepared to pay a minimum co-pay of $75.00 on the date of service.
- Patient-responsible balances are due at your appointment, unless prior arrangements have been made with our billing department.
- In the event you need surgery we will provide you an estimate of your insurance required deductible and co-insurance amounts.
- **We request that at least 24 hour advance notice* to be given to the office if you be unable to keep your appointment. This allows us to release your appointment time to another patients. We may charge an administration fee of $50 for no-shows. Patients who repeatedly "No Show" for appointments may be discharged from the practice.

Proof of Insurance

- Please bring your insurance card(s) and a valid photo ID with you to each appointment.
- It is your responsibility to notify the Practice of changes in your health insurance.

Self-Pay Accounts

- We designate accounts, **Self-Pay**, under the following circumstances: (1) patient does not have health insurance coverage (2) patient is covered by an insurance plan that our providers do not participate in, (3) Patient does not have a current, valid insurance card on file, or (4) patient does not have a valid insurance referral on file.
- Self-pay patients, please be prepared to pay a minimum of $200 on the date of service. This will be applied to the cost of the patient office visit and an x-ray. Additional fees for in office procedures, injections, x-rays, splints, castings, DME or other supplies or services may apply. If you are unable to pay please ask to speak to the billing department to make payment arrangements.

_____ Initials

Referrals

If you have an HMO plan we are contracted with, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, call your primary care physician to obtain it. Without an insurance required referral, the insurance company will deny payment for services. As such, if you are unable to obtain the referral at that time you will be rescheduled or asked to pay for the visit in advance.

Our Responsibility to Report Non-Compliance

It is our obligation under many of the insurance contracts to report patients who repeatedly refuse to pay co-payments/deductibles at time of service or who repeatedly "no-show" for scheduled appointments.

Divorce and Child Custody Cases

- The parent or guardian who brings the child to the office for care is responsible for payment at the time of service no matter if the account is self-pay, participating insurance or non-participating insurance. The Practice does not honor divorce specifics (e.g. Percentage of financial responsibility).
- If the child has coverage with a participating insurance plan and the proper insurance identification is present at the time of service, the Practice will bill that insurance company. Applicable co-payments, co-insurance and/or deductibles are due at the time of service, unless arrangements have been made with the office prior to arrival.
- In cases of divorce, the individual who receives care is responsible for payments of co-payments, coinsurance, deductibles and non-participating insurance balances at the time of service. We will not bill a divorced spouse for the patient's services.

Billing, Payments and Refunds

- If we must send you a statement, the balance is due in full within 14 days of the statement date.
- If you cannot pay the balance in full within 14 days, please contact our billing department to see if you qualify for special payment options.
- It is your responsibility to notify the office of any change in address, phone, employment or insurance coverage.
- If you make an overpayment on your account, we will issue a refund only if there are no other outstanding debts on other accounts with the same guarantor or financially responsible party.
- We reserve the right to report delinquent accounts to credit bureaus, assess a collection fee, take other collection action or terminate you as a patient of this Practice.

_____ Initials — I have read, understand and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

_____ Initials — I authorize my insurance benefits to be paid directly to **Jansen Orthopaedic Clinic**.

_____ Initials — I authorize **Jansen Orthopaedic Clinic**, through its appropriate personnel, to perform or have performed upon me, or the above named patient appropriate assessment and treatment procedures.

_____ Initials — I authorize **Jansen Orthopaedic Clinic** to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

_____ Initials — I authorize **Jansen Orthopaedic Clinic** to contact or discuss patient's personal health information with and/or act as an emergency contact:

(If patient is a minor please put at least one Parents/Guardian name)

Name: _____ Relationship:_____

Phone number:_____ Cell:_____

Name:_____ Relationship:_____

Phone number:_____ Cell:_____

Acknowledgement of Jansen Orthopaedic Clinic Notice of Privacy Practices

I hereby acknowledge that I have reviewed or received or have been given the opportunity to receive a copy of Jansen Orthopaedic Clinic Notice of Privacy Practices.

X_____ Date:_____

Patient/Guarantor Signature