Name:
DOB:
Chart:
Age:
Date:

THE ORTHOPAEDIC GROUP, PC
P.O. Box 86144
Mobile, AL 36689
(251) 476-5050

PATIENT FINANCIAL POLICY

We are committed to providing you with the best possible care and are pleased to discuss, our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR

COPAYMENTS: Your insurance REQUIRES that we collect your designated co-pay at the time of service.
Please be prepared to pay the co-pay at each visit.

SELF-PAY: Self-pay accounts shall exist if a patient has no insurance coverage. For new patients, a payment of $200.00 is expected on the day of your first appointment before being seen by the health care provider. Follow up appointments will require a deposit of $100 at each visit. If you are unable to pay the $200.00 please contact the billing office prior to your appointment. Prepayments will also be required before therapy or surgery is scheduled.

HIGH DEDUCTIBLES: Patients that have high deductibles associated with their insurance plan (greater than $1500) will be required to pay a deposit of $200 on the day of the first appointment each year and a deposit of $100 for each follow up until the deductible is satisfied.

OUTSTANDING BALANCES: If there is a balance due from the patient. you must pay the greater of $200.00 or one half the balance due before being treated by the physician

EXTENDED PAYMENT PLANS: Patients are encouraged to pay outstanding self-pay balances in full. However, payment plans may be accepted with approval of the business office.

REFERRALS: If your plan requires a referral from your primary care physician it is YOUR responsibility to obtain it prior to your appointment and to have it with you at the time of the appointment. If you do not have your referral, you may be required to reschedule

ACCIDENT CASES: <u>Patients shall be financially responsible for medical services related to an accident and self-pay</u> policy as above will apply. We do not accept 3rd party liability insurance.

WORKERS' COMP: It is the patient's responsibility to notify us when you are treated for a work-related injury.

MEDICARE: We will bill Medicare for all covered services. The patient will be responsible for the deductible and the co-insurance, which can be billed to a secondary insurance if you have one.

RETURNED CHECK FEES: Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being assessed a $25.00 fee per check returned.

CHILD CUSTODY CASES: The Orthopaedic Group, P.C. will bill the insurance carrier for both parents;
however, the parent that signs for services will be responsible for all outstanding charges and balance.

WE ACCEPT CASH, MASTERCARD, VISA, DISCOVER, AMERICAN EXPRESS AND CHECKS.
If you have any questions please call the Business Office.

I acknowledge by signing below that I have received the **<u>Patient Financial Policy</u>**

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Patient or patient's Personal Representative **Date**