# FINANCIAL POLICY

This describes our Practice's patient payment procedures for all 'services' (including: exams, tests, supplies, forms completion) rendered to you. In general our Practice agrees to file accurate medical claims on your behalf to your insurance carrier (health, accident, DME, etc.). Patients are responsible for remaining balances resulting from appropriate claims processing**. Please read all applicable sections and sign over the page for assignment of benefits to our Practice, and your acknowledgement of our policies.**

**PATIENTS WITH INSURANCE:** Valid health insurance information must be provided to us to ensure appropriate reimbursement for your care. Patients are responsible for any pertinent deductibles, co- payments, 'non-covered' services, resulting from the insurance claim processing; as well as any documentation or updated information required to process the claim. Failure to provide accurate or required information to ensure proper claims processing will result in immediate patient (or guarantor) responsibility.

**CO-PAYMENTS:** Co-payments are due at the time services are rendered. If you are unable to pay your co- payment today, your appointment may be re-scheduled or a payment plan may be permitted with a promissory note, at the physician's discretion.

**MEDICARE PATIENTS:** As stated above we will file to Medicare on your behalf, and with valid and effective secondary coverage will also forward claims accordingly. As participating physicians in the Medicare program we will collect up to Medicare's allowed amount for covered services, between your insurance and direct payment obligations. Patients are responsible for any resulting coinsurance and deductibles not covered by your additional (secondary, tertiary) insurance. Patients are responsible for non-covered services/supplies under separate notice.

**REFERRALS:** Valid referrals or authorization numbers, as required by your insurance (including worker's compensation carriers), must be received *before* services are rendered. Otherwise your appointment may be re-scheduled or you may be required to pay for today's care, at the physician's discretion. Your pre-payment would be refunded following our receipt of valid referral/authorization and insurance payment for the services we provided.

**WORKERS' COMPENSATION:** Is currently accepted in our Practice on a case by case basis, in accordance with continuity of care and existing contractual agreements. We will file claims to valid W/C carriers. All remaining balances and denied claims are the direct responsibility of the patient throughout the duration of the case. Health insurance information is required in the likelihood of benefit maximums.

**MOTOR VEHICLE ACCIDENT:** Valid motor vehicle insurance with your personal injury coverage (PIP) and/or health insurance must be provided. Please advise us when PIP benefits are exhausted, and forward any payments for our services accordingly. Any remaining balance is the patient's responsibility.

**NO INSURANCE:** Payment is expected at the time services are rendered, unless payment arrangements have been established with our Practice prior to your visit.

**THIRD PARTY LIABILITY**: Currently our Practice does not accept these claims, with the exception of MVA described above.

**FORMS COMPLETION:** Forms will be completed within 3-5 business days of the request. There may be a fee charged for the completion of your forms. For disability forms a fee of $25.00 will be charged.

**STATEMENTS:** On a monthly basis our Practice will mail you an account statement for any outstanding balances due. Payment is expected within thirty (30) days. Failure to make timely payment will result in further collection actions.

**PAYMENT METHODS:** We accept payments by cash, check, MasterCard, VISA, and Discover.

**AUTHORIZATION/ASSIGNMENT OF BENEFITS:** For services rendered to me, I hereby authorize the release of private health information for the purposes of treatment and reimbursement for such care. In addition, I hereby authorize and assign benefits directly to Annapolis Hand Center, LLC. I have read and understand the above described Practice payment policies and patient responsibilities pertinent to me (and/or guarantor).

**SIGNATURE OF RESPONSIBLE PARTY:**

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**PRINT NAME OF RESPONSIBLE PARTY:**

_____ **DATE:** _____

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