FINANCIAL POLICY

Center for Hand & Extremity Reconstructive Surgery, PLC

- **Basic Policy:** All copays and deductibles are due at the time of service.
- **For patients with insurance:** We will bill most insurance carriers for you if a current card and id is provided to us. We will also bill most secondary insurance companies for you. Copays and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we will assist you with your claim within the limits imposed by your insurance company. If an insurance carrier has not paid within 90 days of billing, professional fees are due and payable in full from you.
- **Medicare patients:** We will bill Medicare for you. We will also bill secondary insurance carriers for you. All copayments or deductibles are due and payable at the time service is provided.
- **HMO patients:** All copays are due at the time of service. Required authorizations or referrals are your responsibility, if no authorization is on file, you agree to be responsible for the full balance or we will reschedule your appointment until proper authorization is received.
- **Surgical Fees:** All copays, deductibles, and payments for non-covered surgical procedures are due prior to your surgery. Prior authorization may be required by your carrier.
- **Non-covered Services:** Any care not paid for by your existing insurance coverage will require payment in full at the time of services are provided or upon notice of insurance claim denial.
- **Personal injury cases:** This office does bill for auto accident related cases. You are responsible to provide our office with the claim related details. We do not accept liens.
- **Worker's Compensation:** If your injury is work-related, we will need the case number and carrier name prior to your visits in order to bill the worker's compensation insurance company.
- **Returned Checks:** For checks returned to us as unpaid by your bank, we will charge a $20 fee.
- **Missed Appointments:** In fairness to other patients and the doctor, we require at least 24 hours notice to cancel appointments. You may be charged for missed appointments or dismissed from the practice.
- **Billing Charges:** Unpaid accounts are sent to a collection agency.
- **Occupational Therapy:** Our office offers O. T. services. If you need therapy and another location fits your needs better, you are under no obligation to come here. Please let us know and we will refer you.
- **Forms:** There is a $15.00 charge for filling out special forms.

Medicare patients: Signature on File: I request payment of authorized Medicare benefits be made on my behalf to the Center for Hand & Extremity Reconstructive Surgery, PLC for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable to related services. **If you are a Medicare Home Health Care patient, you CANNOT BE SEEN IN OUR OFFICE********

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Name (please print): _____ Provider

Patient's Signature: _____ Center for Hand & Extremity

Patient's Medicare No.: _____ Date: _____ Reconstructive Surgery, PLC

Assignment of Insurance Benefits: Patients with insurances please read and sign below. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Center for Hand & Extremity Reconstructive Surgery, PLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Signature: _____ Date: _____

I have read, understood, and agreed to the above financial policy for payment for professional fees. **The patient is ultimately responsible for all professional fees.** Signature: _____ Date: _____