OHIO ORTHOPAEDICS & SPORTS MEDICINE, INC.
FINANCIAL POLICY
Effective 03/01/2016

Patient: ____DOB:_________________ Date: __________________

Regarding Your Insurance:
Our office participates in a variety of insurance plans, and we will submit all claims to those carriers. We make every effort to get claims paid; however, please remember that your insurance policy is a contract between you, your employer, and your insurance company. Any balance remaining after the insurance has paid, is the **patient/guarantor's responsibility** (i.e. co-pay, co-insurance, non-covered benefits, exclusions, etc.). If Ohio Orthopaedics & Sports Medicine, Inc. is not in your insurance plan, the patient/guarantor is responsible for all charges. If you do not have insurance, a payment plan must be arranged, prior to treatment, with our Financial Counselor. Partial payment for self-pay patients is required at the time of the initial visit.

In an effort to minimize insurance errors and maximize insurance payment, please bring your most recent insurance cards with you to every visit. **Co-payments are to be paid at time of your visit.** In the event we receive payment from your insurance company for services you have paid for, a refund will be made to you in a timely manner.

Payment Information:
We accept cash, check, and credit/debit card payments. If you are unable to pay your balance in full, a payment plan arrangement can be made or you can sign up for **Care Credit** with the option of no interest financing. Contact our Financial Counselor at 419-424-0131 for more information. These options will lessen the possibility of your account being sent to a collection agency because of non-payment. Any returned check from your bank for non-payment (insufficient funds) shall result in the patient's account being assessed a $25.00 fee per check returned.

Past Due Accounts:
If your balance is not paid in a timely manner, we reserve the right to forward your account to an outside collection agency or an attorney.

Durable Medical Equipment:
As part of your treatment, your physician may prescribe Durable Medical Equipment (including, but not limited to: custom orthotics, braces and splints, etc.). Ohio Orthopaedics will make every effort to authorize this service (if required) with your insurance company. In the event that your insurance company denies payment, or if you do not have DME benefits, you will be responsible for any remaining balance. **Durable Medical Equipment (DME) is non-refundable and may not be returned.**

Assistant Surgeon:
Your physician may determine that it is in your best interest to have an assistant during your surgical procedure. The assistant on your case will be one of our other physicians or one of our physician assistant. We cannot guarantee payment for this service by your insurance company. We will bill your insurance company for the assistant services. If they allow this service we will only bill you for what they **allow.** If they do not allow the assistant, we will bill you a base charge of $300.00 for the assistant services regardless of what is submitted to the insurance company. The basic amount will be your responsibility.

FMLA, Disability Forms:
Any patient requiring forms filled out by our office will incur a $20.00 fee per form. Payment for this service is due at the time of drop-off or pick-up. Forms will not be faxed or mailed until payment is made.

Telephone Consumer Protection Act of 1991 (TCPA):
I authorize my healthcare provider and/or any entity authorized by my healthcare provider including those using automated dialing systems, automated messages, emails, text messaging and/or other electronic communication to contact me for billing purposes using any telephone number, email address and/or mailing address associated with my account.

The medical services you seek imply a financial responsibility on your part. **I UNDERSTAND I AM RESPONSIBLE FOR ANY AMOUNTS NOT COVERED BY MY INSURANCE COMPANY.** Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions regarding your financial responsibility.

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Patient / Guardian Signature Date