FINANCIAL POLICY

Thank you for choosing *Pediatric Orthopaedic Surgery Associates* as your health care provider for your child's orthopedic needs. If you have any questions or concerns about our payment policies, please do not hesitate to ask our business office personnel. This policy must be **read**, **initialed** and **signed** prior to seeing the provider.

Our office accepts assignment with most major insurance companies and participating provider plans

_____ Your insurance policy is a contract between you, your employer, and the insurance company. Our relationship is with you, not your insurance carrier as we are NOT a party to that contract. Should your insurance plan require a referral, it will be the responsibility of the patient to obtain referral.

_____ Deductibles and co-payments are due at the time of service. A credit card is required to remain on file to secure the patients account. All charges incurred are your responsibility regardless of whether your insurance company covers the services rendered.

_____ I, hereby authorize, with the signature below and credit card I have provided ☐MC ☐VISA ☐AMEX ☐DISC ☐HSA/FSA to be billed for any unpaid balances remaining over 90 days past the completion of care. Unpaid balances otherwise are subject to collections via small claims court, attorney, and/or collection agency with applicable collection fees. Collection fees are the responsibility of the patient.

_____ If the insurance company does not process your claim within 30 days we request that you please contact your insurance company and request prompt payment. Please contact our insurance department and inform them of the insurance company's response.

_____ Missed appointments or cancellations of less than 24 hours will result in a $25.00 service fee.

_____ Returned checks will be subject to a $30.00 collection charge. If the check is not picked up and the balance paid within 5 business days, your check will be sent to the Division of Bad Checks with the Johnson County District Attorney for prosecution.

_____ Medical Record base fee is $18.97 and an additional .63¢ per page. Radiology fee is $20.00 per CD. Completion of FMLA or Insurance forms is $25.00

_____ Private pay patients must establish a financial agreement with down payment prior to evaluation. The details of your financial obligation will be determined at that time.

Below is a list of common fractures and the estimated charge collected with **<u>each</u>** fracture that is diagnosed. This amount is **an estimated deposit** of charges that will be applied towards your deductible or coinsurance.

Service	Deposit
Clavicle/Finger/Toe/Foot fractures	$200.00
Hand/Wrist/Elbow/Shoulder fractures	$350.00
Ankle/Knee/Lower Leg/Hip fractures	$375.00
Surgery required	$500.00
Cast/Splints	$75.00 - $200.00
X-Rays	$35.00 - $85.00
Supplies and DME	varies

We understand that temporary financial problems may affect timely payment of your balance, and encourage you to communicate any problems in order to assist you in the management of your account.

Authorization to Release and Assign Insurance Benefits: I authorize release of any information required to act on any insurance claim and permit photographic or another facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to Pediatric Orthopaedic Surgery Associates the medical and /or surgical benefits I am entitled from my insurance company.

This authorization is in effect for all future claims until I choose to revoke it in writing.

I, the undersigned, understand and agree to the above Financial Policy. I understand that by signing this form that I am financially responsible for all charges incurred for the medical treatment rendered to _____
Patient's Name

_____ _____
Printed name of Signee Relationship to patient

_____ _____
Authorized Signature Date

Pediatric Orthopaedic Surgery Associates
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