Orthopaedic Specialists of Charleston
Financial Policy

Thank you for choosing our practice for your orthopaedic service. We are committed to satisfaction and quality care. We value you as a patient and look forward to serving your healthcare needs. Please understand that a sound financial policy is part of every practice. The following is a statement of our financial policy.

INSURANCE

As a participating provider, Orthopaedic Specialists of Charleston follows all mandatory guidelines as specified in each individual carrier's contract. Upon verification that we participate with your plan, we will file your charges with your carrier. With most participating contracts, we are required to collect the full "allowed" amount. (The "allowed" amount is specified by your carrier.) Therefore, you will be expected to pay your co-payment and/or deductible at the time services are rendered. Many insurance carriers have provisions in their policies resulting in non-payment of certain services, such as supplies. In these cases, the patient will be responsible for the non-covered charges.

In the event that a procedure is necessary, we will <u>estimate our charges</u>, your insurance company's payment, and your co-payment. Your <u>estimated</u> co-payment is due prior to your procedure. Upon payment from your insurance carrier, you will be billed or refunded for any difference between our estimate and the actual amount due after your carrier's payment.

If your insurance plan requires a referral or treatment authorization from a primary care physician, it is ultimately your responsibility, as the patient, to ensure that the proper referral has been obtained. Any treatment without the necessary referral may result in a denial of payment by the insurance company, which could make payment for all charges your responsibility.

NON INSURED

If you do not have medical insurance, you will be responsible for your entire bill at <u>time of service.</u> If a procedure is necessary, it must be paid at least 7 days prior to date of service.

MEDICARE

We are a participating provider with Medicare. As an added service, if you have coverage secondary to Medicare, we will also file that for you.

MEDICAID

We are a participating provider with South Carolina Medicaid: however you must have your current card with you at time of service. Your card must have remaining visits to be valid. Please note that WE DO NOT ACCEPT MANAGED CARE/HMO MEDICAID, without proper authorization.

WORKERS COMPENSATION

We will file your workers compensation claim as long as we have authorization for the services. If there is no authorization on file, payment is due when services are rendered.

By signing below, I acknowledge that I have read and understand the Orthopaedic Specialists of Charleston financial policy regarding participating Provider accounts. I further understand that failure to pay as outlined above may result in additional billing, collection agency and/or legal fees.

Signature____Date______________________________

ORTHOPAEDIC SPECIALISTS OF CHARLESTON

Medicare Lifetime Signature on File (for Medicare Patients)

I request that payment of authorized Medicare benefits be made on my behalf directly to this practice for any services furnished my by the physician or physician assistant. I authorize the release of medical information necessary for processing claims to the Center for Medicare and Medicaid Services.

____________ **Initials**

Private Insurance Authorization for Assignment of Benefits/Release of Information

I authorize the payment of medical benefits be made on behalf directly to the Practice for any services furnished me by the physician or physician assistant. I understand that I am financially responsible for any amount not covered by my contract. I authorize the release of my insurance company information concerning healthcare, advice or treatment provided to me necessary for processing insurance claims.

___________ **Initials**

HIPPA Notice Of Privacy Practices Acknowledgement

I have received, read and understand your Notice of Privacy Practices. I understand that this information will be used to carry out treatment, payment and normal healthcare operations of the Practice. I understand that I may request, **in writing**, that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

____________ **Initials**

Durable Medical Equipment & Fracture Care Services

Durable Medical Equipment and Fracture Care may or may not be covered by some insurance plans. DME may be covered as a separate benefit. Fracture Care, which may include casting or splitting, is often considered an in office surgical procedure and benefits may differ from standard office benefits.

____________ **Initials**

Authorization to Release and/or Obtain Medical Records

I hereby authorize my primary care physician, my referring physician and Orthopaedic Specialists of Charleston physicians the release, use and disclosure of my entire medical record by mail, phone and fax to carry out my treatment, payment and healthcare operations.

_____________ **Initials**

Authorized Methods of Communication (check all that apply)

1. OK to leave call back phone number only:
   ☐ Home ☐ Cell ☐ Work
2. OK to leave a detailed message on answering Machine/voicemail:
   ☐ Home ☐ Cell ☐ Work
3. Ok to discuss my healthcare treatment with:
   ☐ Spouse ________________________
   ☐ Family Member_________________
   ☐ Friend_________________________
   ☐ Other__________________________

I understand that the authorization for release of information, assignment of insurance benefits and agreement of financial responsibility will be valid for one year from the date of signature and can only be revoked upon written notice. By signing below, I acknowledge that this form has been read in fill and explained as necessary.

Patient Name**:** _____________________________ Patient Signature**:** ___________________________

Date of Birth**:** _______________________________ Date**:** _______________________________________