FINANCIAL RESPONSIBILITY POLICY

PATIENT NAME_____

It is the policy of this office that all patients, or their guarantors, are financially responsible for the services provided by Orthopedic Associates of SW Ohio, Inc.

1. We expect co-pays to be paid at the time of service.
2. The office asks that all patients assign all insurance company payments directly to the practice to avoid any misunderstandings regarding payment for professional services. The patient will be responsible for any portion of his or her bill that is not covered by the insurance carrier. If the patient is a minor or unable to sign, the responsible party/guarantor who signed the consent to treat will be responsible for any portion not covered by the insurance carrier.
3. If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
4. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
5. Before receiving services, you must verify that we are participating providers for your insurance company. In the event we are not participating providers with your insurance company, we will file an initial claim as a courtesy. Payment, however, is due in full at the time of service. It is your responsibility to verify this prior to your appointment.
6. We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company, and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.
7. We may accept assignment after verification of your coverage. Please be aware that some or perhaps all of the services may not be covered in full by your insurance company. You are financially responsible for services not covered by your insurance company.
8. All patients may be required to pay a pre-service deposit or estimated co-pays and deductibles prior to services (except in emergent situations) or amounts may be collected after services are provided, based on the current business practices of OASWO.
9. You must provide your most current billing address, all available telephone numbers and any other important contact information and if any of this changes, it is your responsibility to contact us with the updated information.
10. If your insurance requires that you have a referral from your Primary Care Physician, it is your ultimate responsibility to ensure that our office receives that referral before your visit. If that is not done, you will be responsible to pay for the provided services.
11. If the doctor schedules a test for you, please check with your insurance to see if it needs precert **before** you have it done. Although we do our best to check, it is ultimately **your responsibility**.
12. We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of any balance, it is your responsibility to contact our billing office within thirty days (30 days after receipt of the initial statement).
13. If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney and will be assessed an additional 35% collection fee plus court costs when applicable.
14. In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $20.00 to your original balance.
15. If you are unable to keep your scheduled appointment, please notify us at least 24-hours in advance so we can accommodate our other patients. Failure to notify the office of your cancellation will result in a $50 no show fee.

We accept various methods of payment including check, credit card, money order and recurring payments. If you need to set up a payment plan, please talk to our billing department. Again, thank you for your understanding and cooperation with this policy.

I do hereby understand and agree with the financial policy of Orthopedic Associates of SW Ohio, Inc.

Date: _____

Signature of Responsible party/Guarantor (if necessary):_____

Date of Birth of Responsible party/Guarantor: _____

Relationship to patient: _____