Advanced Orthopedic
PAIN MANAGEMENT & WELLNESS CENTER

FINANCIAL POLICY

Thank you for choosing us as your health care provider. Our goal is to provide excellent patient care and we are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

WE ACCEPT CASH AND MOST MAJOR CREDIT CARDS

Regarding Insurance Billing

We will bill your insurance company as a courtesy. Your insurance policy is a contract between you and your insurance company. It is your responsibility to know your benefits and how they will apply to your treatment by the doctor. We are not a party to that contract. If your insurance company has not paid your account in full within 60 days, the balance will be transferred to you and/or the guarantor listed on the Patient Information form.

PPO Plans (with which we are contracted): We have agreed to take a discount from your insurance company. Your co-insurance is your responsibility and is due at time of treatment. In the event your insurance coverage changes to a plan where we are not a participating provider you will be responsible for any out of network deductible or coinsurance amounts.

Medicare: We accept assignment with Medicare. Medicare pays 80% of the allowed amount after satisfaction of the annual deductible. We will bill your secondary insurance for the remaining 20% of the Medicare allowed payment as a courtesy; however, you are responsible for the balance of which Medicare or your secondary does not pay.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Cash patients

All services must be paid in full at time of treatment.

Administrative Fee

All co-pays will be collected at the time of service. If a patient does not submit payment at the time of service, the patient will be billed for the co-pay and a $15 Administrative Fee will be added. In addition, any patient invoices that are not paid within thirty days of the invoice date, a $35 fee will be added to the current bill.

Benefit Reassignment Agreement

Below please find the benefit reassignment agreement policy of Advanced Orthopedic Pain Management & Wellness Center Inc. regarding payments for services.

I,_____, hereby irrevocably assign the insurance benefit payment, both basic and major medical, to which I am entitled directly to the doctor rendering services. I understand that I am financially responsible for the charges not covered by my medical insurance policy. I understand that it is my responsibility as the patient to become familiar and understand coverage of services and benefits under my insurance plan. I hereby authorize the doctor providing medical services to release any information required during the course of my examination or treatment. I also acknowledge that any payments I receive directly from any insurance carriers services rendered by Advanced Orthopedic Pain Management & Wellness Center Inc. are the sole property of Advanced Orthopedic Pain Management & Wellness Center Inc. I agree not to cash those payments and to submit them directly to Advanced Orthopedic Pain Management & Wellness Center Inc. within one week of receiving such payments.

Please do not hesitate to contact our staff with any questions or comments regarding this document.

By signing this document, I understand both the Financial Policy *and* the Benefit Reassignment Agreement with Advanced Orthopedic Pain Management & Wellness Center.

Name (Please Print): _____

Signature: _____

Date: _____/_____/_____