Financial and Billing Policy

UNIVERSITY ORTHOPAEDICS PHYSICAL THERAPY

Thank you for choosing University Orthopaedics and Physical Therapy, PC. We are committed to the success of your treatment. We hope you understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read, agree to and sign, prior to any treatment. This financial policy applies to all services rendered by our providers.

It is our policy that the patient, rather than the insurance company, is responsible for complete payment of charges. All patients with insurance coverage are required to pay for non-covered services, any deductible amount not previously met, and any co-payment and co-insurance amount due at the time services are rendered. For patients with dual insurance coverage, we will bill both the primary and secondary insurance if you have provided us with the necessary information. PLEASE NOTE: AFTER 120 DAYS (4 MONTHS) OF ATTEMPTED COLLECTION FROM YOUR INSURANCE, ALL BALANCES ARE DUE AND PAYABLE BY THE PATIENT. We will be happy to provide you with any documentation needed to obtain reimbursement from your insurance company.

Patients insured under a plan which we are NOT contracted with will be required to pay for the first visit in full. For any follow-up visits you will need to pay 20% at the time services are rendered.

If you are insured with a plan, which we ARE contracted with (including Medicare), you will need to pay for any non-covered services, any outstanding deductible and your co-payment/co-insurance prior to treatment.

Patients with no health insurance coverage are expected to pay for services at the time services are rendered.

Failure to make payment arrangements, or pay outstanding balances within 30 days of notification of amount due, may result in termination of care from University Orthopaedics and Physical Therapy, PC.

Our accepted methods of payment are cash, personal checks and all major credit cards. If requested, a short payment schedule may be arranged for patients who have special financial conditions.

It is the patient's responsibility to verify their benefits for their particular plan and to make sure all proper authorizations have been obtained. Some insurance plans will reduce benefits if the insured is treating with providers outside of the designated network or without the proper authorization.

CO-PAYS, CO-INSURANCE AND DEDUCTIBLES

All Co-Pays, Deductibles and Co-Insurance are required to be paid at the time of service. Should the practice need to bill for a Co-Pay a $10 fee will be added.

HEALTH INSURANCE

University Orthopaedics and Physical Therapy, PC. will bill your health insurance carrier as courtesy to you if presented with the information and assignment of benefits at the time of service. All applicable co-pays, deductibles and co-insurance must be paid at the time of service.

PAYMENT RESPONSIBILITY

In the event the insurance claim submitted is denied, the patient will be held responsible for all charges incurred during his/her treatment.

RETURNED CHECKS

There will be a $30.00 fee for any returned checks.

WORKER'S COMPENSATION

It is required at the time of service that the patient gives Worker's Compensation and health insurance information. Charges for services incurred as a result of a work-related injury will be billed to the Worker's Compensation carrier or the employer. Upon denial by Worker's Compensation, the health insurance carrier or the patient will be responsible.

MANAGED CARE (HMO)

Unless an authorization is obtained from your PCP, or your health care carrier, you will be responsible for payment in full at the time of service. Your insurance will be billed as a courtesy to you.

REFUNDS

All refunds must be requested in writing and a refund will be issued to the appropriate party within 2 weeks.

CANCELLATION AND NO-SHOW

Since we do have limits to how many patients we can see each day, it is important that you notify us at least 24 hours in advance of your appointment should you need to cancel or reschedule. This includes scheduling a same-day appointment and later canceling it.

When one doesn't show up for his/her appointment or cancels with little advanced notice, it takes away our opportunity to provide another patient attention for a medical need.

Any patient who fails to show up for an appointment, or fails to give at least 24-hour advanced notice of cancellation, will be subject to a fee of $50. If you have an appointment on a Monday and need to cancel or reschedule, please call the office on Friday. Our answering service does not take messages for the office after hours.

Again, thank you for trusting us with your care. If you have any questions regarding financial responsibilities or payment options, please contact our insurance department.

"I have read, understand and agree to the provisions of this policy"

Patient/Legal Guardian Signature: _____ Date: _____

Name (Please print): _____

Relationship to Patient (if other than patient): _____