



MOA

PATIENT FINANCIAL POLICY

As healthcare providers we are committed to providing our patients with the best medical care possible. As a business, we are committed to providing a streamlined fiscal process that allows our patients to clearly understand their financial responsibility. Our Business Office is committed to providing outstanding customer service for all financial questions, and our professional staff members are experts working with commercial insurance companies, Medicare, and Workers' Compensation.

Identification

- Proper identification must be presented prior to service being rendered
- Current insurance cards must be presented prior to services being rendered.

Commercial Health Insurance

- *HMO Patients*-must obtain a Referral Form from their Primary Care Physician prior to service.
- *Co-payments*
 - Insurance companies require that co-payments are collected prior to service.
- *Co-Insurance/Deductibles*
 - New co-insurance or deductible amounts will be billed after the date of service
 - These amounts can only be calculated after your appointment
- *Non-Participating Insurance*
 - MOA does not contract with every insurance company.
 - Patients are responsible for asking if MOA is a participating provider with their insurance company.
 - MOA will bill non-participating insurances. However, outstanding balances are the responsibility of the patient.
- *Secondary Insurance*- as a courtesy MOA will file to your secondary insurance carrier.

Medicare

- MOA will submit claims to Medicare, however you may need to sign an ABN form for non-covered services.
- MOA will submit to Medicare as your secondary insurance carrier.

Workers' Compensation

- Patients shall be financially responsible for medical services related to Workers' Compensation.
- Patients shall supply WC contact information prior to services being rendered.

Motor Vehicle/Third Party Liability

- Patients shall be financially responsible for medical services related to motor vehicle accidents.
- Motor vehicle accidents and third party liability cases will be liened by MOA and settlements will be primary.
- Patients shall supply auto insurance, third party, and/or attorney information as requested by MOA.

Self-Pay

- Self-pay accounts exist if patients have no insurance coverage.
- A \$210 payment is required prior to your physician or therapy appointment. You will be billed the balance after the appointment. If you are unable to make a payment please contact the Business Office prior to your visit. All outstanding Balances are also expected to be paid prior to your office visit.

Statements/Payments

- *Statements*
 - Statements are sent to patients on a monthly basis and will show outstanding balances.
 - After insurance pays, patients are responsible for all outstanding balances.
- *Payment Methods*
 - We accept All major Credit Cards, HAS, checks, money orders, and cash.
 - Payment plans are available. Patients need to discuss options with the Customer Service Representative.
- *Returned Checks Fees*-a fee \$25.00 will be charged for all returned checks.

By signing this document below I hereby give Midland Orthopedics Associates permission to bill my Insurance and receive direct payment for all services rendered.

Credit Card Policy/Authorization

- In order to meet the patient responsibility of your health plan, we require patients to provide a valid credit card at the time of service. Your credit card information will be stored in a completely secure environment. No charges will be applied to the card until your claim has been processed by your insurance company and they have determined your financial responsibility. Please note that all co-payments, as required by your plan are due at the time of service. If a credit is not obtainable at the time of service patients are required to make a deposit of \$210 prior to services being rendered.
- If there is a remaining balance after your insurance carrier pays, you will have 30 days to make a payment on the invoice. If no payment is received and the billing department has not been contacted on your behalf the credit card on file will be processed for the said balance.

Consent to Access Surecripts Information

I grant permission to MIDLAND ORTHOPEDIC ASSOCIATES to access the information regarding his/her prescribed drugs and medications. This information is maintained by SURESCRIPTS, a medical information clearing house. The information obtained is for the sole purpose of providing medical care for the patient by Midland Orthopedics Associates and will be maintained in the strictest confidence in the patient's medical record at MIDLAND ORTHOPEDIC ASSOCIATES.

Notice of Privacy Practices

I acknowledge receipt of Midland Orthopedic Associates' *Notice of Privacy Practices*. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that Midland Orthopedic Associates has reserved a right to change its privacy practices that are described in the Notice. I also understand that a copy of any revised Notice will be promptly provided to me or made available.

This consent will remain in force until revoked in writing by me, the patient.

Please provide Midland Orthopedic Associates with the name(s) and relationship (spouse, parent, child etc.) of any individual(s) in which we may disclose any information (health, financial etc.).

I hereby assign, to Midland Orthopedics Associates, payment of medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine my benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand I am financially responsible for all charges whether or not they are covered by my insurance policy, as well as any co-payments, co-insurance or deductibles.

Patient Name: _____ **Date:** _____

Guardian Name (If patient is a minor): _____ **Date:** _____

Patient Signature: _____ **Date:** _____

Guardian Signature (If patient is a minor): _____ **Date:** _____