MICHIGAN ORTHOPEDIC CENTER

FINANCIAL POLICY

Patient Name: _____

Thank you for choosing Michigan Orthopedic Center as your orthopedic provider. We are committed to your treatment being successful. Please be advised that payment for your services is part of your treatment. We ask that you read and acknowledge this policy prior to any treatment.

PATIENT RESPONSIBILITY

Adult patients are responsible for payment at time of service. The adult (parent or guardian) accompanying a minor is responsible for any payments due. All patients are required to complete our registration process prior to seeing any of our providers. Providing accurate and valid insurance information is the responsibility of the patient and/or adult representative.

- **Co-Payment, Co-Insurance and outstanding deductibles are due at time of service**
- Cash, Check and Credit Card payments are accepted
- MSUFCU's patient credit card is also accepted

INSURANCE

Not all services may be covered benefits under your insurance; Medicare and many insurance carriers have specific coverage guidelines that may limit coverage for certain services. We will work closely with you and your insurance company and do our best to identify non-covered services before your visit. However, you will still be financially responsible for payment.

If we do NOT participate with your insurance company, full payment is due at the time of service. For insurance plans that we participate with, we will submit a claim on your behalf. All patient responsibility balances are due at the time of service***. New patients with Deductible Health Plans (greater than $400) will be required to pay a $400 deposit towards services provided. Established patients with Deductible Health Plans (greater than $200) will be required to pay a $200 deposit towards services provided.*** When multiple insurance carriers are involved, we will follow standard procedures for filing of primary, secondary and tertiary claims.

WORKER'S COMPENSATION, LIABILITY OR AUTO INSURANCE FOR MEDICAL SERVICES

In cases of third party liability, we do not consider the existence of an ongoing legal action a valid reason for delay of payment. Patient and/or guardian is responsible for prompt payment.

COLLECTIONS

We will provide statements of balances due for any non covered services, deductibles or other patient responsibility. We reserve the right to utilize a third party vendor in an effort to collect outstanding account balances.

MISSED, CANCELLED, OR RESCHEDULED APPOINTMENTS

We encourage patients to keep all scheduled appointments. If you accumulate more than 3 missed appointments, we reserve the right to dismiss you from our practice. We request 24-hour notice for any rescheduled or cancelled appointment. Your account will be charged a $50 fee for failure to give proper notice.

DISABILITY FORMS AND/OR FMLA DOCUMENTATION

If you require completion of disability or FMLA forms, we assess a $20 fee. This payment is required prior to our completion of any forms.

X

Signature of Patient or Responsible Party Date Patient Date of Birth

Printed Name of Patient