AUGUSTA ORTHOPEDIC SURGERY, PLC
FINANCIAL POLICY

We would like to thank you for choosing Augusta Orthopedic Surgery. In order to keep you informed of our current office and financial policies we ask that you read and acknowledge these policies prior to your treatment. We are dedicated to providing the best possible care to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

1. **INSURANCE**: Patients must present current insurance verification (card) at every appointment due to current federal and insurance regulations; all co-payments and co-insurance are collected at the time of service. The co-pay requirement **cannot be waived by our practice**, as it is a requirement placed on you by your insurance carrier. If you do not have your co-payment on the date of service we will be glad to reschedule your appointment. You are responsible for obtaining a referral if required by your insurance company. If a referral is not obtained, you are responsible for payment in full on the day of service. If it is discovered after your visit a referral is needed, you will be responsible for the full payment at that time. Insurance information submitted to us past the timely filing date, will be your full financial responsibility. If you have an insurance with which we do not participate, we ask that payment be made at the time of service. It is your responsibility to understand the terms and conditions of your health insurance coverage; and all financial responsibility ultimately rests with the patient. As a courtesy to our patients we file insurance claims on their behalf.
2. **WORKERS' COMPENSATION**: If your injury is due to an accident in your workplace, please be sure to contact your employer and inform them of your injury. We will need authorization and information from your employer before your visit so that claims can be properly filed. Denied claims will be your responsibility.
3. **PRIVATE PAY PATIENTS**: We will give a discount to people with no insurance if paid on date of service. New patients without insurance must pay a **minimum of $90.00 for the first visit** and **established patients must pay a minimum of $70.00** at scheduled appointment. This amount is a discounted price for the visit. If additional charges for x-rays, splints, casts, etc occur a 30 percent discount may be applied if payment is made on date of service. If you are not able to pay the additional charges on date of service you must make arrangements to pay balance in full within 30 days of services rendered.
4. **FMLA OR DISABILITY FORMS**: There will be a charge of $25.00-$50.00 for the completion of medical forms (the charge is based on the number of pages and complexity of information requested). Payment is due at time of request. Please allow 7-10 business days for forms to be filled out.
5. **MEDICAL RECORDS** will be supplied upon request. You will need to sign a letter of release at the time of pick-up. Please allow 7-10 days for us to copy your records. If you need your records mailed there may be a charge for mailing costs. We reserve the right to charge .50 cents per page for 1-50 pages, and .25 cents for page 50 +. There is a $5.00 charge for copies of x-rays (CD).
6. **PATIENT BALANCE**: All balances that are due from patient after insurance has paid will be billed promptly on our normal monthly cycle and considered delinquent after thirty (30) days. We appreciate your prompt payment in full for any outstanding balances. If you are unable to pay a balance in full, please notify our Billing Department immediately to arrange a payment plan. Accounts that are ninety (90) days past due are considered for collections. In the event that your account is sent to collections you may incur additional costs, including interest on unpaid balance, legal, attorney and collection fees. We will not schedule any follow-up appointments until collection balances are paid in full. We are always willing to work with you to keep your account in good standing.
7. **There is a $25.00 fee for returned checks**.
8. **There may be a $35.00 fee for appointments that you do not keep without at least a 24 hour cancellation notice**.

I hereby have read and understand Augusta Orthopedic Surgery's financial policy. I hereby consent to treatment necessary for the medical care of patient named below. I authorize the release of any medical records to the referring or family physician(s), to any health care provider that the patient named below may be referred to and to insurance or third party payer indicated in this patient's chart, if applicable. I authorize payment of all charges incurred for the account of the below patient to Augusta Orthopedic Surgery and understand that I am responsible for payment of any amount not covered by insurance.

_____ _____ _____ _____

PRINT PATIENT NAME DATE PATIENT OR GUARDIAN SIGNATURE (SEAL) Date

_____ _____

WITNESS SIGNATURE DATE Patient account #_____

03/2016

AUGUSTA ORTHOPEDIC SURGERY, PLC

Authorization for Use or Disclosure of (PHI) Protected Health Information

I hereby authorize the use and disclosure of individually identifiable health information related to me, which is called (PHI), protected health information, under a federal health privacy law, as described below.

I, _____, give authorization for **AUGUSTA ORTHOPEDIC SURGERY, PLC** to discuss, release or obtain my private health information to/from the following:

Name_____Relationship_____

Name_____Relationship_____

Are there any restrictions on PHI to be disclosed: ____Yes ____ No If yes: _____

_____**NO ONE OTHER THAN MYSELF MAY HAVE ACCESS TO MY MEDICAL RECORDS**.

May our office leave a message on your answering machine: ____ Yes ____ No

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I understand that Augusta Orthopedic Surgery, PLC is part of an organized healthcare arrangement that includes providers that may share my health information for treatment, billing and for healthcare operations. This office does maintain protocols to ensure the security and confidentiality of your personal information. We maintain security in our building, passwords to protect databases, compliance audits and virus/intrusion detection software. Within our practice, access to your information is limited to those who need it to perform their jobs. A copy of this organization's notice of privacy practices that describes how your health information is used and shared is available in the waiting room for reading.

I understand that Augusta Orthopedic Surgery utilizes The Prescription Drug Monitoring Program if questions arise regarding prescribing of narcotic medication. I understand that I am granting permission for Augusta Orthopedic Surgery, PLC to inquire about medication prescribed to me by any physician within the past one year of this date through The Prescription Drug Monitoring Program website.

I understand that the organized healthcare arrangement has the right to change this notice at any time. I may obtain a current copy or receive additional information by contacting the hospital patient advocate at (540) 932-4742, the privacy officer at this office by phone (540) 885-1281, or by visiting our website at www.augustaortho.com.

My signature below acknowledges that the privacy notice has been made available to me.

_____ _____

PRINT PATIENT NAME Date

_____

Signature of PATIENT or LEGAL REPRESENTATIVE

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