ORTHOPAEDIC SPECIALISTS

Better experience. Better results.

FINANCIAL AGREEMENT

Thank you for trusting Orthopaedic Specialists, P.C. ("OS") to partner in your health care. This financial agreement should answer questions regarding patient and insurance responsibility for services rendered. Please read this agreement, ask any questions you may have, and sign in the space provided. You may request a copy of this agreement for your records.

Insurance

We accept and participate in a variety of insurance plans. Proof of insurance must be provided on every date of service. Your insurance coverage is a contract between you and the insurance company, and it is your responsibility to know your insurance benefits. As a courtesy, we will bill both your primary and secondary insurance companies. We will submit necessary claims and assist you in any way we reasonably can to facilitate claims processing. If there are any changes to insurance coverage, please notify us prior to time of service. You are responsible for any charges not covered by your plan.

Co-payments/Deductibles

All co-payments must be paid at the time of service. By contractual law, your insurance company requires us to charge for, and you to pay for, all required co-payments, co-insurances, and non-covered services. You are responsible for any unsatisfied deductibles.

Worker's Compensation/Liability

If you are being treated as a result of a work related injury, motor vehicle accident, premises liability claim and/or any other liability injury claim, you must notify us prior to the time of service and provide claim information regarding potentially responsible parties, insurance companies and attorneys. Insurance approvals may be needed prior to treatment. You are responsible for any charges not covered by insurance. Additionally, as consideration for OS providing medical services, you agree that OS shall have a lien on any and all proceeds derived from and/or related to your injury claim (whether by settlement, judgment or otherwise) to secure payment of all fees and expenses owed by you and/or your insurer to OS. You further agree that this lien will take priority over any and all other liens, subrogation interests and/or assignments of any of your interests, and that this lien will be paid in full before disbursement of any proceeds from any recovery related to or arising out of your injury claim.

Self-Pay Patients

New patients without insurance or insurance coverage that cannot be verified prior to time of service are required to pay a deposit of $200 on or before the first date of service. The deposit will be applied to treatment given and any remaining balance will be your responsibility. As a courtesy, self-pay patients may be offered a discount on any charges upon payment in full.

Administrative Services and Fees

- Forms: There is a $10 fee per form for completion of FMLA or other disability forms. This fee must be paid prior to the forms being completed.
- Medical Records Requests: Patients must complete an authorization form prior to the release of records. Patients will be charged a reasonable fee for the preparation of records; this fee must be paid prior to records being prepared for release.

Non-Payment

We understand that financial circumstances may vary from patient to patient. If you are unable to pay your patient balance in full, you must call our billing office at (563)344-2296. Failure to pay balance within 60 days will result in being referred to a collection agency, which may affect your credit. Accounts referred to a collection agency will be charged a nominal collection fee.

I have reviewed this financial policy, and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts will be referred to a collection agency. If my account is referred to collection, I agree to pay for all costs and expenses, including reasonable attorney fees. I acknowledge that I have been offered a copy of this agreement for my records.

Patient Signature	Printed Name	Date
Parent/Guardian Signature	Printed Name	Date