

## **SOUTHWEST MICHIGAN CENTER FOR ORTHOPAEDICS & SPORTS MEDICINE**

### **FINANCIAL POLICY**

Thank you for choosing Southwest Michigan Center for Orthopaedics & Sports Medicine for your orthopaedic care. We are committed to providing the best care possible.

The following Policy document explains our financial policy, which we ask you to review at this time and sign.

### **INSURANCE**

Orthopaedic surgery is a specialty practice and your insurance carrier may require that you obtain a referral from your primary care provider before being seen. As the insured member, this is **your** responsibility. We recommend that you contact your health insurance carrier to determine whether you need a referral before scheduling an appointment.

Our practice participates in most local insurance plans and we can provide you with the list of insurance companies that we do participate with. Ultimately, however, it is **your** responsibility to determine whether or not we are a participating provider for your insurance carrier.

You must provide your insurance card at every visit and we ask that you tell us of any changes to your address, phone number, employment status, or insurance coverage. We will also ask for a copy of your driver's license as this is standard protocol for medical practices in Michigan. If you do not have the information requested, i.e. insurance cards or driver's license, we may ask you to reschedule your appointment.

### **CO-PAYS, DEDUCTIBLES, AND NON-COVERED SERVICES**

All co-payments, deductibles and non-covered services are due at the time of service. We cannot waive co-pays or deductibles, as this would be a breach of contract between you and your insurance carrier. It is your responsibility to know your provisions for co-pays and deductibles as this is a contract between you and your insurance carrier. Our practice will not become involved in disputes between you and your insurance carrier. All services may not be considered a covered service by your insurance company. This then makes you financially responsible for these services. It is necessary that you understand your healthcare is not dictated by your health insurance carrier, but by what the physician feels necessary to provide you the best care. If we schedule an elective surgery for you, we will be checking with your insurance company. If it is found that deductibles have not been satisfied or that co-pays will be owed, full payment of these fees will be required prior to the surgery date.

## **CLAIM SUBMISSION**

We will submit claims to all insurance companies in which we are participating providers. Our staff will be more than willing to help you in submitting claims to insurance companies that we do not participate with. Your insurance carrier may require you to supply certain information directly to them. It is **your** responsibility to comply with their request.

## **WORKMAN'S COMPENSATION**

If you have experienced a work injury approved under a workman's compensation claim, you must obtain authorization from your employer's insurance carrier in writing before your visit. You must bring the following information: claim number, insurance carrier name and address, date of accident, and employer information. We cannot see you under a workman's compensation claim if this information is not present at the time of visit. Also, we can not bill your regular insurance for an injury that occurred at work. If you do not have this information we will have to reschedule your appointment.

## **NON-PAYMENT**

If your account becomes 60 days past due, you will receive a letter reminding you that you must satisfy this debt and pay the account in full within 15 days. Please be aware that if a balance remains unpaid we will then refer your account to a collection agency.

Your medical care is a valued service and your compliance with the financial responsibilities of this service is appreciated. Please understand that our financial staff is happy to work with you. Also, understand that a lack of insurance coverage or underinsurance does not remove your responsibility for the full payment at the time of service.

## **RETURNED CHECK**

In the event that we receive a returned check due to insufficient funds, a \$30 fee will be charged to your account and payment is due upon receipt of your statement.

## **INSURANCE FORMS, MEDICAL RECORDS, AND DISABILITY FORMS**

We charge a fee for completing insurance forms, copying medical records, and completing disability verification. These activities are extremely time consuming for our staff and cannot be expected to be performed free of charge. Also, be aware that these services require seven to ten business days to complete.

## **FORMS OF PAYMENT**

For your convenience, we accept cash, check, MasterCard and Visa. We also participate in the Care Credit Program, which is a creative way of providing low cost financing for medical care. Our billing representative will be more than happy to explain these services to you. Please do not hesitate to ask if you have any questions. Often bill

disputes are the result of miscommunication and our financial personnel pride themselves on excellent customer service and their ability to help our patients deal with the often difficult financial circumstances that illness and injury present.

Your signature below signifies that you have read and understand our financial policy. Further it acknowledges your responsibility regarding charges related to your care.

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Patient's signature (if 18 or older)

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Date

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Guardian's signature

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Date