

## **TRINITY ORTHOPEDICS FINANCIAL POLICIES**

- First and foremost we want to express our appreciation to you for selecting our practice. We want all your experiences with us to be positive.
- This form represents our office policies and guidelines concerning financial responsibility. We ask that you sign the last page of this form indicating that you read and understand these guidelines. If you have any questions please consult with a member of our office staff.
- We require a copy of your current insurance card prior to or at the time of your visit. **If you are unable to present your card before seeing the doctor, the visit may be considered fee for services and full payment may be collected.** If you are an established patient, please verify all information and notify us of any changes.
- If we are a participating provider for your insurance we will file your claims for you. When your insurance processes the claims we will make the appropriate adjustments. Please note that you will be responsible for any copays or coinsurance amounts as set forth by your insurance company. **Your copays are due at the time services are rendered.**
- As a rule we try to verify all benefits prior to your appointment but in some cases this is not possible. It is **ultimately your responsibility** to make sure we are a provider, what your benefits are, and that you have active insurance and have supplied us with that information, when applicable, the appropriate referral is obtained. In the event your insurance claim is denied **you will be responsible** for the services rendered.
- We know that filling out these forms can be difficult, but please complete them carefully. Your accurate responses will give us a better understanding of your and your problem. This enables us to provide you with the best possible medical care. Thank you for your cooperation!
- **Under some plans/policies you are required to obtain a referral from your PCP (Primary Care Physician) before seeing a specialist. If your plan requires a referral it is your responsibility to ensure that our office is in the possession of the referral letter or number prior to your visit. If the referral is not made available to our office by the time of your visit you may choose copay for the visit yourself or reschedule your appointment. If you elect to pay for the visit, you assume responsibility for collecting from your insurance company. Please note that most referrals are issued for a specific time frame and to a specific doctor; we must insist that you verify the validity of your referral in relation to each visit.**
- From time to time your insurance company may request further information from you before processing your claim. Failure to comply with this request in a timely manner may result in a denial of your claim. In the event that this happens, **you will be held responsible** for the entire balance of this claim.

- If you have an indemnity policy we will file your insurance claims as a courtesy. Please be prepared to pay for your portion of the claim at the time services are rendered. You are **responsible** for the entire balance in the event that your insurance does not pay. We will allow 30 days for your insurance to process before holding you liable for the unpaid balance by your insurance carrier.
- If you are private pay (fee for service, please be prepared to pay at the time services are rendered. If surgery becomes necessary you will need to contact our billing office. In the event that your account becomes past due we will make a concentrated effort to collect but when necessary we will employ the use of an outside collection agency.
- If you have work related injury and are worker's comp it is your responsibility to provide our office with all the necessary information required to file your claims. This includes insurance carrier, mailing address and phone numbers, employer, address and phone numbers, adjuster's name and numbers, referring doctor, date of injury, what the compensable injury is, and claim number. You will not be billed for any balance unless your claim goes in dispute. In this case you may be held responsibility for the balance's on the claims being disputed.
- We accept cash, personal checks and most major credit cards. There will be a \$35.00 charge for any and all returned checks. When necessary, any unpaid returned checks are delivered to the District Attorney's office for collection.
- **I have read and understand the financial policies for Trinity Orthopedics as set forth in the preceding paragraphs. My signature indicates my willingness to comply fully or accept responsibility for payments of any claim denied due to noncompliance. My signature also authorizes this office to file claims for me and assigns all medical right and benefits due for these services. My signature authorizes this office to release medical records as necessary to my insurance carrier:**

\_\_\_\_\_  
Signature of patient (parent / guardian, if patient is a minor)

\_\_\_\_\_  
Date