WISSAHICKON ORTHOPAEDIC SPECIALISTS, P.C.

ACCT #: _____

FINANCIAL POLICY & OFFICE REGULATIONS

THANK YOU FOR CHOOSING US AS YOUR ORTHOPAEDIC SPECIALIST. WE ARE COMMITTED TO PROVIDING YOU THE BEST POSSIBLE CARE & ARE PLEASED TO DISCUSS OUR PROFESSIONAL FEES WITH YOU AT ANY TIME. PLEASE READ AND SIGN ACKNOWLEDGING THE REGULATIONS.

CO-PAY: WE ARE A SPECIALTY OFFICE; THEREFORE, YOUR CO-PAY MAY BE HIGHER. PLEASE CONTACT YOUR INSURANCE COMPANY FOR YOUR SPECIALIST CO-PAY AMOUNT.

ALL CO PAYS AND OUTSTANDING BALANCES WILL BE COLLECTED UPON CHECKING IN FOR YOUR SCHEDULED APPOINTMENT. WE ACCEPT CASH, PERSONAL CHECKS, VISA, MASTERCARD, DISCOVER AND AMEX.

INSURANCE: WE WILL SUBMIT A CLAIM TO THE INSURANCE COMPANY FOR WHICH YOU HAVE PROVIDED THE INFORMATION. IN INJURY CASE WE REQUIRE MEDICAL PRIMARY AND SECONDARY INSURANCE AS WELL AS ANY CHANGE OF INSURANCE. IF CLAIMS ARE DENIED BY YOUR INSURANCE COMPANY, YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL.

FAILURE TO PROVIDE COMPLETE INSURANCE INFORMATION MAY RESULT IN THE BILL BEING CHARGED DIRECTLY TO YOU.

UNINSURED PATIENTS: IF YOUR INSURANCE COMPANY IS NOT CONTRACTED WITH US, YOU AGREE TO PAY ANY PORTION OF THE CHARGES NOT COVERED BY INSURANCE. THE ACTUAL BALANCE WILL NOT BE KNOWN UNTIL TREATMENT HAS BEEN PERFORMED AND COMPLETED.

YOU ARE RESPONSIBLE FOR THE ACTUAL CHARGES AND NOT THE ESTIMATED FEES. PAYMENT IS DUE AT TIME OF SERVICE.

MINOR PATIENTS: THE ADULT PARENT OR GUARDIAN ACCOMPANYING THE MINOR IS RESPONSIBLE FOR PAYMENT OF MINOR PATIENT'S ACCOUNT REGARDLESS OF WHO THE INSURANCE POLICY HOLDER IS. FOR UNACCOMPANIED MINORS NON-EMERGENCY TREATMENT CAN BE DENIED UNTIL A PARENT OR GUARDIAN IS PRESENT OR WE HAVE WRITTEN PERMISSION FOR TREATMENT.

FOR MINORS: PATIENT'S GUARDIAN WILL BE FINANCIALLY RESPONSIBLE FOR PATIENTS ACCOUNT.

MISSED APPOINTMENTS: FAILURE TO GIVE 24 HOUR NOTICE OF CANCELLATION OF YOUR APPOINTMENT WILL RESULT IN A $25.00 FEE. WE WILL NOT BILL YOUR INSURANCE COMPANY; THIS WILL BE YOUR RESPONSIBLE FOR PAYMENT.

FAILURE TO GIVE 24 HOUR CANCELATION NOTICE WILL RESULT IN A $25.00 CANCELATION FEE.

DELINQUENT ACCOUNTS: IF YOUR ACCOUNT BECOMES PAST DUE YOU WILL RECEIVE A COLLECTION WARNING FROM US. IF RECEIVED PLEASE CONTACT THE OFFICE AS SOON AS POSSIBLE. OUR STAFF CAN ASSIST YOU TO SET-UP PAYMENT ARRANGEMENTS. FINANCE FEES WILL BE ADDED FOR COLLECTION ACCOUNTS. AFTER (90) DAYS, YOUR ACCOUNT WILL BE REVIEWED FOR TO SUBMIT TO COLLECTION AGENCY.

ONCE ACCOUNT IS PLACED IN THE OUTSIDE COLLECTION AGENCY ARE DISCHARGED FROM ANY FUTURE SERVICES OR TREATMENT.

HIPPA PRIVACY POLICY: I UNDERSTAND THAT, UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1998 (HIPAA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED TO CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY AND INDIRECTLY.

COPIES OF THE HIPPA PRIVACY POLICY ARE MADE AVAILABLE AT THE FRONT DESK.

PLEASE SIGN BELOW AFTER YOU HAVE READ AND ACKNOWLEDGED THE ABOVE REGULATIONS.

PATIENT NAME: (PRINT) _____ **DATE OF BIRTH: _____**

PATIENT SIGNATURE: _____ **DATE SIGNED: _____**