

## Financial Policy and Statement of Responsibility/Prairie Shoulder, Elbow & Hand Center

Thank you for choosing Prairie Shoulder, Elbow & Hand Center (PSEH). The following is a statement of our FINANCIAL POLICY. All patients must accept our FINANCIAL POLICY before receiving treatment. Full payment of your bill is considered a part of your treatment. While we will assist you in any way we can to obtain payment of benefits from your insurance company, we will not accept responsibility for payment or denial of benefits. Ultimately, it is the patients and/or guardians responsibility to promptly and fully pay all charges for services and supplies provided by the clinic.

**METHOD OF PAYMENT:** WE ACCEPT CASH, CHECK, VISA, MASTERCARD, DISCOVER AND CARE CREDIT. Interest at 18% APR will be charged on patient balances 60 days or older.

**FOR PATIENTS WITH INSURANCE:** As a courtesy to you, we will submit medical claims to your insurance company. **Any balance after processing of our claim by your carrier is your responsibility.** Your insurance policy is a contract between you and your insurance company. You are responsible for verifying if providers are in-network with your insurance company. **All co-pays are due prior to treatment.**

**DISABILITY AND INSURANCE FORMS:** **There will be a charge for \$10 for the completion of medical forms filled out by Dr. Hurlbut.** Please allow 7-10 days for the completion of these forms. If you would like the forms mailed to you or your insurance company, payment will be due prior to mailing of the forms.

**LIABILITY CLAIMS & AUTO ACCIDENTS:** We will file any insurance claims for services related to an auto or third party liability. We will accept health insurance payments after the auto or liability has paid. By signing below you agree to assign all benefit dollars to PSEH for services provided.

**WORKERS COMPENSATION:** If your injury is work-related, we will need the case number, carrier name and information prior to your visit in order to bill the worker's compensation insurance company. The patient is ultimately responsible for all professional fees if a worker's compensation claim is denied.

**SELF PAYMENT ACCOUNTS:** **We require a \$200 pre-payment at your initial visit.** All total charges will be discounted by 20%. We are happy to accept payment by cash, check, credit or debit card. If your remaining balance reaches 45 days past due and you have not contacted us to make payment arrangements, your account may be turned over to our collection agency. If surgery is recommended, we expect payment in full prior to the procedure.

**LIENS:** Liens may be placed on accounts related to auto accidents, liability or denied worker's compensation with attorney coverage. The lien will be placed on the person causing the accident, the patient's attorney, the patient, the attorney of the person causing the injury (if known) and the insurance company. We will not accept health insurance payments or take contractual adjustments.

**WHEN SURGERY IS RECOMMENDED:** For individuals with a commercial insurance plan, our surgery coordinator will verify your eligibility and benefits and work with you to determine your out-of-pocket expenses. Financial arrangements will need to be made to meet your financial responsibilities prior to your surgery. **A prepayment deposit of \$250 - \$500 will be due prior to the date of your surgery.** Should you cancel your scheduled surgery and do not reschedule, a \$50 nonrefundable eligibility verification fee will be retained.

In the case of divorce, the parent signing this Financial Policy and Statement of Responsibility is responsible for any and all payments for services. Any legal agreement, or other disagreement, between two parties in a divorce must be dealt with between those parties and does not involve PSEH.

**COPIES OF THE MEDICAL RECORD:** With your consent, PSEH may transfer copies of your medical record, or portions thereof, to you or a third party, including but not limited to your personal representative, your health insurance carrier, attorneys, physicians involved with your care, your workers compensation carrier, and/or liability carriers. **The minimum charge to copy records is \$20 plus \$0.50 per page plus applicable sales tax.**

**CONSENT:** I hereby request and consent to medical care including all examinations, tests, and other procedures which my physician and his assistants deem necessary or appropriate. I acknowledge that no guarantees have been made as to the results of such medical care. By signing this form, I also agree to all of the terms and conditions described above.

**AUTHORIZATION:** I have read and agree to the terms and conditions on the financial policy and I hereby authorize the release of any medical information necessary to process my health insurance and request payment of benefits to the provider of services. I understand I am financially responsible to PSEH for charges not covered or denied by my insurance company. Please keep this document for future reference.

**I further agree in the event of my non-payment, to pay the cost of collection and/or court/attorney costs and reasonable fees should this be required. (Please read the back of this form for more detailed payment information)**

I assign all benefit proceeds for services rendered by PSEH. Proceeds to include health insurance, worker's compensation, third party liability, and other benefit proceeds.

(see reverse)

I hereby certify that I have read, understand, and agree to the information set forth above, and certify that if I am not the patient, I am duly authorized to sign for the patient. If you have questions regarding this policy, please do not hesitate to ask.

Patient Name \_\_\_\_\_ Guarantor Name \_\_\_\_\_

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_

### Detailed Payment Information

**Office Visits:** Office charges will be determined by your physician following your exam today. Office charges may include: initial exam, x-rays, injections, fracture care with casting, and any supplies. Upon completion of your visit, staff will work with you to determine your portion of the bill which is payable today.

**Global Periods or Fracture Care:** Any patient that undergoes a surgical procedure or is in a fracture care category will be billed using a global period. This means that for 90 days (10 days for Medicaid recipients) following your surgery all follow-up care with the physician is already covered. This does **not** include further needed xrays, supplies, therapy or injections.

**Surgery:** Since you (or your employer) have chosen an insurance carrier with particular benefits and because insurance coverage is a complicated business with no fixed rules, please check with your insurance carrier in regard to the specifics of your proposed surgery. Also, please note that the hospital bill is not something we can control, so please direct any questions regarding the specifics of the hospital, lab and anesthesia bill to the hospital billing office where your surgery was or will be performed.

Arthroscopic operations and total joint replacements are complex and require a trained surgical team. Dr. Hurlbut works with another fully trained physician's assistant who assists him during the operation. Normally this is Lygia Plioplis, MPAS, PA-C. You will receive a bill for her services as well.

Our Surgery Coordinator will verify your eligibility and benefits and work with you to determine your out-of-pocket expense for your particular surgery. Financial arrangements will need to be made to meet your financial responsibilities prior to your surgery. A pre-payment of \$250 - \$500 will be due prior to the date of your surgery to cover your out-of-pocket expenses. Should you decide to cancel a scheduled surgery and do not reschedule, a nonrefundable \$50 eligibility verification fee will be retained.

### Frequently Asked Questions

**What is a co-pay?** Typically, the co-pay is a set amount the consumer will pay to see a physician. For example, an office visit to your physician might have a co-pay of \$30; Dr. Hurlbut is an orthopedic specialist so therefore your specialist co-pay would apply to your visit here, e.g., \$60. Your carrier requires that all co-pays be paid prior to any services being rendered. This co-pay requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier.

**What is co-insurance?** Co-insurance is a percentage of the allowed cost either the insurance or consumer will pay. For example an 80/20 plan typically represents that the insurance will pay 80% of the allowed cost and the consumer is responsible for the remaining 20% of the allowed cost, after the consumer's deductible has been paid.

**What is a deductible?** A deductible is an annual dollar amount established by your insurance plan the consumer must pay before insurance benefits are applied. This amount is your obligation and must be paid prior to having surgery.

**What are out-of-pocket expenses?** All expenses not covered by insurance that you are responsible for paying for via cash, check, credit or debit.