Financial Policy

We are committed to providing the best possible care to our patients and feel this goal is best achieved if our patients are aware of our office policies. Your clear understanding of our financial policy is important to our professional relationship.

Timely Payment:

We are doing everything possible to keep the cost of medical care down in our practice. You can help a great deal by eliminating the need for us to bill you. **Full payment is expected at the time of service unless other arrangements have been made in advance.** This especially includes applicable deductibles, co-insurance and co-payments for participating insurance companies. Our office accepts cash, personal checks, American Express, Discover, Visa, and Master Card. You will be given a receipt for all payments. An itemized receipt is available on request, however, please allow us time to select and apply all government required codes.

Benefit packages provided by insurance companies vary from employer to employer. It is vital that you make yourself aware of benefits as stated on *your* policy. We will bill the insurance companies with whom we are contracted, but if we are not paid in a timely fashion, you may be expected to pay the bill in full. Except as provided by such contract or by state law, we are obligated to hold you responsible for all charges.

If you are experiencing financial difficulties, please let our benefit coordinators know. In most cases, a patient who presents this to our office with an urgent problem, will not be turned away because of financial problems.

No Shows:

Please notify us in advance if you are unable to keep your appointment. Appointments not cancelled 24 hours in advance to the scheduled appointment time may be subject to a cancellation/no show fee of $50 per office visit. Extenuating circumstances will be taken into consideration. After three “No Shows” for your scheduled appointments, you will be considered noncompliant and qualify for dismissal from the practice.

Referrals:

If your insurance plan requires a referral in order for you to see a specialist, please contact your primary care physician to confirm that one has been issued to our physicians, and that the referral is on file with your insurance, prior to any appointment.

Medicare:

There are physicians in this group who do not participate in Medicare. Services provided by opted out physicians require a Medicare Private Contract. **This is true whether Medicare is your primary or your secondary insurance.** This is Federal Regulation, so we appreciate your understanding and cooperation with this requirement. Services from participating providers will be billed to Medicare in the standard fashion.

Returned Checks:

There is a $30.00 charge for any check returned to us from the bank unpaid plus applicable charges added by our outside collection agency. Returned checks are also reported to the Attorney General.

Refunds:

If you believe you are due a refund for an overpayment, please review the following TruOrtho Refund Policy:

1. Your episode of care must be completed prior to any patient refund. All claims within your episode must be finalized with your insurance. This will take at least 90 days for your claim(s) to process. We have no way of pushing this issue. Several factors may further delay the completion of the episode of care. Included are:
   (a) Medical records requests from the insurance companies
   (b) Their assessment if anybody else should be responsible
   (c) Final determination of which insurance is primary vs. which is secondary. It is very common for an insurance company to pay as if they were primary, then decide after the fact that they should have been secondary. In this case they will demand their money back, sometimes more than a year after they have paid. To avoid this, we often have to review, and get the insurance company to verify that they are the primary payor.

2. Please call the office to request a refund. All patient refund requests are directed to the TruOrtho Practice Manager, and not to the billing office. Please do wait until at least 90 days after the service was provided as this is the earliest that the insurance companies might consider the episode of care to be completed.

3. After requesting a refund, and after TruOrtho has determined the episode of care is complete, your account will be audited, and if a credit is verified, a check issued. This process can take an additional 2-4 weeks.

Again, the purpose of the refund policy is to allow time for TruOrtho to submit your claim(s), for your insurance to process your claim(s) and to issue proper payments and EOBs to TruOrtho. Some instances involve second level appeal, as well as refund requests from insurance companies on previously processed claims that require more time and review. We do wish that we had more control over these issues, but the insurance companies both work on their own time, and can be quite fickle.

Collections:

All fees are due at the time of service. Any charges remaining unpaid sixty (60) days after the date of service are considered past due. In this case, we will make every effort to contact the person responsible for the delinquent balance and arrange an equitable payment schedule. However, if no effort is made to pay the balance due, it may be sent to an outside collection agency. In this situation, the patient may be asked to seek medical care elsewhere.

Payment arrangements on outstanding balances will be carried no longer than a four (4) month period.

1. I have read and understand the TruOrtho's financial policy.
2. I agree to keep TruOrtho's accurately informed of my insurance status and to assign benefits to TruOrtho's if necessary. I also understand that should I fail to do so, I will be responsible for payment in full immediately.
3. I agree to keep TruOrtho's accurately informed of my current mailing address and telephone numbers.

4. I agree that if it becomes necessary to forward my account to a collection agency, I will be responsible for any processing fees in addition to the original amount due.

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Patient Name (Please Print)

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Responsible Party Name (Please Print)

_____

Patient/Responsible Party Signature

____/_____/_____

Date