ROBINWOOD ORTHOPAEDIC SPECIALTY CENTER

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FINANCIAL POLICY

It is the policy of Robinwood Orthopaedic Specialty Center (ROS) to provide quality health care service for our patients. ROS needs your assistance and understanding of our financial policy.

- ROS are providers for many Insurance plans and will be listed in your group's provider directory if we are participating. We will bill your insurance directly and receive payment directly from these plans.
- Most plans require a co-payment per visit and/or have yearly deductibles. We require that co-payments be paid when you arrive for your appointment.
- If your Insurance plan requires a written referral from your Primary Care Physician, it must be presented upon your visit. Patients may be rescheduled if not obtained.
- For those Insurances that we do not participate with, a 20% PAYMENT OF TODAY'S TOTAL CHARGE WILL BE EXPECTED UPON CONCLUSION OF YOUR VISIT. As a courtesy, ROS will file your insurance. However, you will be responsible for any and all payments that your Insurance company has not satisfied.
- If you do not have insurance, PAYMENT IS EXPECTED AT THE TIME OF SERVICE. We accept Visa, MasterCard, and Discover. If payment in full is not possible, budget plans are available and can be arranged at your request. A discount is offered for those patients that pay their balance in full the day that services are rendered.
- If you are being seen for an injury, please advise us of any other party that is responsible for primary payment. We will submit to workmen's compensation and automobile accidents. In addition, we will need copies of your insurance cards for our records. In the event that the claim is denied or PIP is exhausted, we can bill your private insurance for your convenience.
- You will receive a bill from us for any portion that is not covered by your plan or what they have deemed your responsibility, and payment will be expected within 30 days of receipt. ROS will work with all patients to resolve payment issues. However, to prevent outside intervention, please inform us of any financial difficulties you may be experiencing.
- If your account becomes assigned to a collection agency, you will be responsible and agree to pay 33-1/3 % collection agency fees, court cost, and attorney fees.

I hereby authorize Robinwood Orthopaedic Specialty Center to furnish information, including records from other health care providers to my insurance company, authorized agency, or health care provider specified concerning my medical care and to process claims. I hereby assign and transfer any medical benefits due me to Robinwood Orthopaedic Specialty Center for the services provided to me by this medical practice, I permit a copy of this authorization to be used in place of the original. Regulations pertaining to Medicare Assignment of Benefits apply, as applicable.

I hereby authorize Robinwood Orthopaedic Specialty Center to treat me as needed. Also, I acknowledge receipt of the Notice of Privacy Practices.

______________________________ Date

______________________________ Signature

I hereby authorize Robinwood Orthopaedic Specialty Center to treat __________________________________,
being ______________ years of age and a minor. I understand that I am fully responsible for this minor's medical charges and agree to pay all charges for services rendered by the above-named medical practice. Also, I acknowledge receipt of the Notice of Privacy Practices.

______________________________ Date

______________________________ Signature (Parent or Legal Guardian)

______________________________ Printed name of parent or guardian

______________________________ Relationship to patient