

Financial Policy

Our Financial Policy is as stated:

- All applicable co-payments, co-insurance, or deductibles are due prior to your visit with the physician
- Payment in full at the time of service if uninsured or non-contracted. If you cannot make full payment at the time of service, a financial agreement must be signed prior to your visit. First payment is due on date of first visit.
- We accept cash, checks, Visa or MasterCard.

Insurance

We are contracted with Medicare, numerous PPO networks and managed care plans. Please be aware that some or all of the services provided may be considered by your insurance to be “non-covered” services and may not be considered medically necessary under your plan’s provisions. You will be responsible for these charges. Please check with you insurance company or your insurance handbook for information regarding your “non-covered” services.

If you policy requires you to have a referral or authorization by your primary care physician, it is your responsibility to obtain it prior to your appointment. Failure to obtain and present referral form or authorization at the time of service may result in a loss or reduction of benefits. You will be responsible to pay for services that are denied for lack of referral or prior authorization unless under our contract with the insurance company, they have deemed it the physician’s responsibility to obtain the referral or authorization. It is your responsibility to notify this office of any changes to your insurance coverage; failure to do so, resulting in denial of our services will become your responsibility, and will require you to pay the balance of the services provided.

Your insurance coverage is a contract between you and your insurance company. We are not a party to this contract. We will submit all charges to your insurance carrier as a service to you. If you have any questions, please feel free to ask for assistance.

I have read the above policies and agree to them, I authorize Hot Springs Bone and Joint to furnish information to my insurance company, worker's compensation carrier, or attorney concerning my injury and treatment. I understand that I am financially responsible for payment of all services not covered by my insurance carrier.

I authorize payment of benefits directly to Hot Springs Bone and Joint for services provided.

X _____ / / _____
Signature of patient or responsible party Date

I acknowledge receipt of Hot Springs Bone and Joints Notice of Privacy Practices.

Signature Date

My medical information may be released/disclosed to and used by the following individual or organization:

- a. _____
- b. _____
- c. _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____ .

If I fail to specify an expiration date, event or condition, this authorization will expire in sixty days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Patient Signature _____ Date: _____