Policy Section: Patient Accounts	Policy #: 13.00
Policy: FINANCIAL POLICY	**Date:** March 2, 2011
Recommended By: FINANCE DIRECTOR **Approved By: FINANCE COMMITTEE**	**Revised:** July 31, 2013

POLICY:

It is the policy of ORTHOPEDIC CENTER OF ILLINOIS (OCI) to provide a copy of the company's financial policy to every patient. The patient must sign the Financial Policy in order to receive treatment.

PURPOSE:

To ensure patients are aware of their financial obligation for services received.

PROCEDURE:

1. The financial policy includes information about the company's policy as it relates to the following:
   a. Insurance
   b. Co-pays
   c. Self Pay
   d. Workers' compensation
   e. Liability Injury
   f. Elective Pre-Paid Procedures/Exams
   g. Form Fee
   h. Statements
   i. Finance Charges and Return Check Fees
   j. Uncollectable Account
   k. Collection Costs and Procedures

2. Personal Information (social security number, name and address, date of birth, valid phone number, insurance policy information, etc.) must be collected to in order to both extend credit and to bill insurance companies. OCI may also need to convey this billing information to third parties, i.e., radiology services, electronic billing information, hospital scheduling departments, etc.

   a. Since OCI is granting the patient **credit** by rendering services to the patient prior to full payment for those services, the patient will be required to provide their social security number, which is solely for business purposes.

   b. If patient chooses not to provide OCI with the proper billing information, they will not be extended credit by OCI and will be treated as a self pay patient, requiring payment in full on the date of service.

      i. The patient will be required to

1. give their full name, date of birth, and a valid phone number for proper follow up,
2. provide credit card information prior to their appointment,
3. will be given the self pay discount of 50%, and
4. will be allowed to pay with cash or credit card after their appointment.

ii. The patient will not be
1. allowed to pay with a check, nor
2. extended any credit; which includes a budget arrangement.

iii. If the patient does not accept these self pay terms nor does the patient provide the personal information we require, the patient will not be seen.

3. The financial policy is posted on OCI's website and presented to patients when they register at the front desk. See the attached Financial Policy.

a. The patient may be given a hard copy to sign or they may be presented with an electronic copy to sign. After the patient has read the financial policy, a Front Desk Receptionist staff member will ensure that all of their questions are answered.

b. If the patient refuses to sign the financial policy, the patient will be referred to Patient Accounts for further explanation. If they continue to refuse to sign, they will not be seen.

FINANCIAL POLICY

The following statement is our Financial Policy. It is required that the patient and/or responsible party (hereinafter referred to as "you") read and sign this statement prior to any treatment. All patients and/or responsible parties must also complete and sign our Information and Insurance form prior to treatment.

INSURANCE

We are contracted with many insurance companies. For companies that we do not have contracts with, we reserve the right to accept or deny assignment of insurance benefits. If we accept assignment of benefits it is your responsibility to supply our office with a copy of your current insurance card. If we do not participate with your insurance company, then your insurance policy is a contract between only **you** and your insurance company. The balance on your account is your responsibility. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 30 days, you will be expected to pay your balance. Please keep in mind that some, and perhaps all, of the services provided may be a non-covered service under your insurance plan and that payment for the service is your responsibility. Any reduction of payment or denial of payment by your insurance company due to "usual and customary rates" is your responsibility to pay. Our charges are based on the usual and customary rates for our area. They are **not** based on the determination of any insurance company.

CO-PAYS

All co-pays and deductibles are due at time of service. If you are unable or unwilling to pay the co-pay, your appointment will be rescheduled until such a time that you can pay the co-pay.

SELF PAY

A $125.00 payment is due prior to treatment from all uninsured new patients. If you are being seen for a follow up visit, you will be required to pay $75.00 prior to your visit. Any additional balance due will be required at check out on the day of your visit. **WE ACCEPT CASH, CHECKS, VISA OR MASTERCARD.**

WORKERS' COMPENSATION

You must notify us prior to being seen by the physician if we are seeing you for a work related injury. Your employer must complete and sign an "employer's worker's compensation claim acknowledgement" form. It is your responsibility to bring this completed form with you along with all billing information for your account (carrier name and address, contact person, telephone number and claim number if applicable). This information must be provided to us prior to treatment.

LIABILITY INJURY

If you are being seen due to a liability injury you must provide the following information for billing and verification of payment prior to treatment:

***Auto Accident:** if you were injured in your own car you must provide us with the name and address of your auto insurance company, your agent/adjuster's name, telephone number, your claim number and date of accident.
If your injury occurred in someone else's car, we require all of the above information "and" the following, their name, the name and address of their auto insurance company, their agent/adjuster's name, telephone number and their claim number. We do not bill 3rd party insurance.

***Slip and fall, etc:** if you were injured on residential property or in a residential dwelling, we require the following, homeowner's name, the name and address of their homeowner's insurance company, their agent/adjuster's name, telephone number, their claim number and the date of accident. If your injury occurred at a place of business, please provide basically the same information.

If your account is not paid in full within 60 days, you are responsible and will be expected to pay your unpaid balance. The Orthopedic Center of Illinois will not accept a delay in payment due to settlement disputes and/or litigation. We may accept assignment of your health insurance benefits.

PRE-PAY REQUIREMENTS FOR SURGERY AND MRI

All elective procedures will require a down payment prior to the date of the procedure. A discount is available if you pay the balance in full prior to the date of your procedure, otherwise, a down payment is due prior to the procedure and the balance will be charged to your credit card monthly for the next two (2) months.

ASSIGNMENT OF BENEFITS AND RELEASE OF RECORDS

You do hereby assign to the Orthopedic Center of Illinois, Ltd., the medical benefits to which you, or your dependents are entitled. You also authorize the Orthopedic Center of Illinois, Ltd., to furnish to your health insurance company all your patient information including but not limited to any and all medical records, notes, test results, x-ray reports, MRI reports or other documents related to your treatment (including itemization of any charges and payments on your account) that is deemed necessary to process this claim. You also authorize the Orthopedic Center of Illinois, Ltd., to release any and all patient information and medical records necessary to collect this debt. Please refer to our Notice of Privacy Practices for information on how we protect your privacy rights.

FORM FEES

If you have forms that need to be completed by a physician or nurse, a fee will be charged to you. The fee is required to be paid in full prior to any form being completed. Examples of these forms include but are not limited to; disability forms and FMLA forms.

STATEMENTS

Within a week of your account balance becoming your responsibility, you will be sent a statement reflecting the balance due on your account. You will receive statements no more than once every thirty (30) days.

FINANCE CHARGES AND RETURN CHECK FEES

You agree to pay a finance charge at the rate of 1½**%** per month (18% per year) on all unpaid balances commencing 60 days from the date of service. You also agree to pay a $ 20.00 service charge on all return checks.

DELINQUENT ACCOUNT

You understand that your balance is due upon receipt of your statement. If you do not pay the balance in full within 60 days of the statement, your account will become delinquent.

COLLECTION COSTS AND PROCEDURES

If your account does become uncollectable, you agree to pay all costs incurred, including but not limited to, all reasonable attorney's fees, filing fees, court costs, and collection agency contingency fees. You understand that a fee ranging from 40%-70% will be added to the total balance due. By signing this policy you do acknowledge that we reserve the right to release any patient information and any medical records to our collection agency deemed necessary to assist their staff and their attorneys in the collection of this debt. You also give the collection agency the right to contact you via telephone number, including cellular. In addition, you are giving both Orthopedic Center of Illinois and the collection agency permission to obtain a report from a credit reporting agency and to take reasonable steps to verify your credit and or employment information.

For your information, the health care professionals in this practice are financially integrated. If you are referred to a health care professional in this practice for imaging, or physical therapy services, please note that you may request and receive a referral for these services independent of this practice.

By signing below you affirm that you read and understood our Financial Policy and that you agree to its contents.

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Signature of patient or responsible party Date