ORTHOPEDIC CENTER OF ILLINOIS

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. Your clear understanding of our Financial Policy is important to our professional relationship.

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.

INSURANCE

We participate with many insurance companies. 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. 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. Regarding insurance plans where we are participating providers, when co-pays apply, we are required by the insurance company to collect these at the time of service. Please be prepared to pay your co-pay prior to each visit.

It is the patient/responsible party's responsibility to provide Orthopedic Center of Illinois the most current and up to date changes with their insurance coverage. If this information is failed to be provided to us on the date of service, we cannot bill timely or do prior authorizations as needed. In these cases, it is the patient's responsibility for payment.

NON-COVERED SERVICES:

If your insurance plan determines that a service is non-covered under your plan, you will be responsible for payment of those charges they deem allowed and non-covered. This includes Durable Medical Equipment (DME). Some DME items may be considered non-covered by your insurance plan and you will be given the option to pay for it at the time of service.

USUAL AND CUSTOMARY, NON-PARTICIPATING PLANS, or OUT OF NETWORK

It is ultimately the patient's responsibility to verify whether Orthopedic Center of Illinois contracts with your insurance plan. Insurance plans will often use the terms "usual and customary" or "out of network" when discussing our fees. 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.

SURGERY CHARGES

A representative from Patient Accounts may contact you regarding a surgery pre-payment for elective surgeries and procedures. This is calculated based off any remaining deductible, applicable co-pays and/or coinsurance that your insurance company has provided to us.

WORKERS' COMPENSATION

You must notify us prior to being seen by the physician if we are seeing you for a work-related injury. You must provide us with all work comp billing information, including the claim number, adjuster assigned, and policy information prior to being seen. We may accept assignment of your health insurance benefits.

LIABILITY INJURY

We do not bill 3rd party insurance. If you do not provide your personal health insurance information and you have a liability claim, you will be responsible for payment as a self-pay patient and can turn that information over to the applicable party.

MINOR PATIENTS

The following parties are responsible for payment of the minor's account balance: the adult accompanying the minor and the parents (or guardians of the minor). We do not get involved in divorce situations. The parent that signs for the child will be financially responsible and any statements will be mailed directly to that parent. A minor that is not accompanied by an adult will be denied any non-emergency treatment unless charges for the treatment have been pre-authorized.

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.

"NO SHOW" APPOINTMENTS

If you are unable to keep your scheduled appointment, please be courteous by canceling at least 24 hours in advance. Multiple "no show" appointments may result in you not being allowed to schedule future appointments with our physicians.

RECORD REQUESTS AND FORM FEES

Your records are available to you at any time through our patient portal, Follow My Health. You can sign up for a portal account on our website: www.orthocenterillinois.com/followmyhealth. Records for encounters prior to your registration on the portal must be requested through the website. Your x-ray and MRI images are not available through the portal but can be requested on the website. There is a $10 fee for a cd of your images. Forms such as those for FMLA and Disability are processed by an outside company, and they will charge a fee prior to completion of these forms.

APPOINTMENT REMINDERS VIA TEXT

I understand that to have my appointment reminders sent via text to my cellular phone, messaging and data rates may incur.

RESIDENTS AND SCRIBES

Most of the OCI physicians are also teaching physicians for the SIU School of Medicine. As such, they sometimes have residents with them during office hours and during surgery. Additionally, some OCI physicians may use scribes to help document your visit in your medical records. If you wish to not have either or both of these participate in your care, you must tell the physician prior to the start of your appointment.

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 $25.00 service charge on all return checks. If you have 2 checks returned, you will no longer be allowed to pay for your charges by check.

COLLECTION COSTS AND PROCEDURES

If my account becomes delinquent, I agree to pay all costs incurred, including but not limited to, all reasonable attorney's fees, filing fees, court costs, collection agency contingency fees. I understand that a fee ranging from 40%-50% 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. I also give the collection agency the right to contact me via telephone, including cellular. In addition, I am giving the collection agency permission to obtain a report from a credit reporting agency and to take reasonable steps to verify my 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 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.

X_____ _____

Signature of patient or responsible party Date