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.

SELF PAY
A $150.00 down payment is due prior to treatment for all self-pay patients, including those who are uninsured, out-of-network, or have pending workers' compensation claims. This down payment applies to both new and established patient visits.

We offer a 50% discount on applicable charges when the total balance is paid in full on the day services are rendered. If the remaining balance is not paid in full on the day of service, charges will revert to the full applicable rate. The $150.00 down payment will be applied toward the total balance due.

WE ACCEPT CASH, CHECKS, VISA OR MASTERCARD.

INSURANCE
We participate with many insurance companies. 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 60 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.

Regarding insurance plans where we are participating providers, all co-pays and deductibles are due at time of service.

USUAL AND CUSTOMARY
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.

WORKERS' COMPENSATION
All workers' compensation billing information must be provided prior to treatment, including the name and address of carrier, claim number, and adjuster contact information. Treatment must be authorized by the workers' compensation adjuster before services are rendered.

If workers' compensation information is incomplete, pending, or if authorization has not been obtained at the time of service, you will be required to comply with our Self-Pay Policy or reschedule the appointment once workers' compensation treatment has been authorized. If your workers' compensation claim is denied for any reason, you are responsible for the charges. In such cases, we will accept assignment of your health insurance benefits if applicable. Any remaining balance after insurance processing will be your responsibility. If the Self-Pay policy is utilized and workers' compensation later approves the claim, a refund will be issued only in accordance with our refund policy listed below.

The Orthopedic Center of Illinois will not accept a delay in payment of your account due to claim disputes or litigation.

LIABILITY INJURY
If you are being seen for an injury resulting from an automobile accident, slip and fall, or other liability-related incident, we do not bill third-party liability insurance carriers or attorneys.

You are responsible for payment of all charges in accordance with our Self-Pay Policy or through assignment of your health insurance benefits, if applicable. You are responsible for submitting any receipts or documentation to the third-party liability carrier or insurance company for reimbursement.

The Orthopedic Center of Illinois will not accept a delay in payment of your account due to settlement negotiations or litigation.

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). 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.

"FORM" FEES

A fee applies to the completion of forms and medical documentation. Payment is required in full prior to completion. Examples include, but are not limited to, disability forms, FMLA paperwork, attending physician statements, and personal injury documentation. Documents may be completed by a third-party vendor on behalf of our office and are subject to a fee. Form fees are non-refundable once completed. Please allow 7-10 business days for processing.

Cellular Data Contact/TEXT

I understand that to have any and all cellular contact sent via text to my cellular phone, messaging and data rates may incur.

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.

OVERDUE BALANCES

Balances are considered overdue if unpaid after 90 days from the date of service. Overdue balances may be required to be paid in full or in part prior to being seen by the physician for non-emergent services. This determination is made at the discretion of the Orthopedic Center of Illinois (OCI).

REFUNDS/OVERPAYMENTS

In the event of an overpayment, any credit balance may be applied to other outstanding dates of service on the account, including balances owed to the Orthopedic Center of Illinois (OCI) and the Orthopedic Surgery Center of Illinois (OSCI). If a refund is deemed applicable, it will be issued at the discretion of OCI and in accordance with guidelines established by the accounting department.

COLLECTION COSTS AND PROCEDURES

If my account becomes delinquent, I agree to pay all costs incurred, including reasonable attorney's fees, filing fees, court costs, and collection agency contingency fees. I understand that a fee of 40%–50% may be added to the total balance due. By signing this policy, I authorize the release of any patient information and medical records necessary for collection efforts. I authorize the collection agency to contact me by telephone, including cellular, and to obtain credit reports and 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