

Cape Fear Orthopaedic
FINANCIAL POLICY

Patient Name: _____ Chart # _____

The intent of this document is to inform you of Cape Fear Orthopaedic’s financial policies. Because we are committed to providing you with the best possible care and service, it is essential that you have a complete understanding of your financial obligations.

FORMS OF PAYMENT – We accept Cash, Checks, Money Orders, Traveler’s checks, Debit cards, MasterCard, Visa and Discover Card.

SELF-PAY PATIENTS – All self-pay patients and patients who present without proof of insurance are required to pay for all charges at the time of service. If you are unable to pay in full, you **must** see any Patient Representative to make financial arrangements **prior** to being seen by your provider. A separate payment agreement is required if you cannot pay in full.

PARTICIPATING INSURANCE PLANS – If you have an insurance plan that we are currently contracted with, we will submit your insurance claim once you have provided us with the necessary copy of your insurance card. You are responsible for any services not covered by your insurance including deductibles, co-insurance, copayments and non-covered services. Please be prepared to show your health insurance card at each visit.

COPAYMENTS – Your insurance **REQUIRES** that we collect your co-pay at the time of service. Please be prepared to pay the co-pay at each visit. If you cannot pay your co-payment, your appointment may be rescheduled. Chronic non-payment is grounds for dismissal from the practice.

NON-PARTICIPATING INSURANCE PLANS or “OUT OF NETWORK” – As a service to our patients, we will file your insurance claim even if we do not participate with your health plan. Because these insurance payments will generally come directly to you, we do require that you pay for all charges at the time of your visit.

WORKER’S COMP – Worker’s compensation laws require an employee to report injuries to their employer. If your visit involves a work related injury, you must provide us with all appropriate information related to your claim, including the name and phone number of your adjuster.

AUTO INSURANCE and other THIRD PARTY LIABILITY – We do **not** accept auto insurance or other third party liability insurance. If you are being seen for an injury due to an automobile accident or third party liability, you will be responsible for paying for all charges at the time of your visit.

CHILD CUSTODY (MINOR CHILDREN) – Our practice will bill the insurance for both parents (if applicable). However, the parent that accompanies the child to his/her first appointment will be considered responsible for payment, regardless of the subscriber (parent) listed on the child’s insurance card. We do **not** get involved in child custody issues.

RETURNED CHECK FEES – A \$25.00 returned check fee will be assessed to your account after each returned check. A patient will be considered “Cash Only” if two (2) checks are returned for non-payment.

NO SHOW FEES – We may charge a \$20.00 “no show” fee if you fail to keep a scheduled appointment or fail to cancel an appointment with at least 24 hours notice. Repeatedly missing, rescheduling, or cancelling appointments may be grounds for dismissal from the practice.

NON-PAYMENT – If you have an outstanding balance and have been billed more than once, without payment, you may be required to reschedule your appointment. Chronic non-payment of bills you are directly responsible for can be grounds for dismissal from the practice. We reserve the right to turn any account over to a collection agency if the account is not paid within 30 days.

I have read the Financial Policies of Cape Fear Orthopaedic and agree to comply with these policies. I hereby assign to Cape Fear Orthopaedic Clinic any insurance or other third-party benefits available for health care services provided to me and authorize the release of my Protected Health Information (PHI), if necessary, to ensure payment of my insurance claims. I understand that Cape Fear Orthopaedic has the right to refuse to accept assignment of benefits in certain circumstances. If these benefits are not assigned to Cape Fear Orthopaedic, I agree to forward insurance or third-party payments that I receive for such services not previously paid for, immediately upon receipt.

X _____
Signature of patient/legal guardian

Date