

Metrocrest Orthopaedics & Sports Medicine

Welcome! Please read the following office policies and let us know if you have any questions.

1. If you do not have insurance coverage, payment is expected at the time of service. The cost of a new patient office visit is estimated at \$300.00, depending on x-rays, casting, braces, etc. If you do not have a method of payment available or if you are unable to afford this minimum, please let us know prior to your visit/
2. Please review your charge ticket and report what you feel to be discrepancies at the time of service.
3. If surgery becomes necessary, there may be a surgery deposit required depending upon your insurance plan.
4. Please sign in at the front desk. Please complete the paperwork in it's entirety.
5. Please pay your co-pay when you check in. If you do not have your co-payment, we may ask you to reschedule your appointment. We do not accept post-dated checks.
6. Please have your driver's license and insurance card ready. We must have a copy of your current insurance card on file at the time of service. If you do not have a valid insurance card, you will be responsible for the full amount of the visit. Please inform our office 24 hours prior to your appointment if your insurance has changed.
7. Please contact our office with any address, telephone, or insurance changes.
8. Please schedule separate appointments for each injury or illness.
9. As a courtesy to all our patients, you may be asked to reschedule your appointment if you are more than 20 minutes late.
10. If the patient is under the age of 18, that patient's guardian will be required to be present at the time of visit. We do not see unaccompanied patients under 18.
11. Your insurance company may require additional information to process your claim(s) such as accident details, co-ordination of benefits or student status. Your insurance company will request this information in writing. Our office will also notify you that your insurance is requesting more information. It is very important that you provide your insurance with the information necessary to process your claims. You are allowed 10 days to get this information to your insurance company. If, after 10 days your insurance company has not received this information from you, the balance will become your responsibility and you will receive a statement from us for payment in full.
12. After your insurance carrier has paid their portion, there may be an amount not covered and a balance due. We will send you a statement. The balance is due within 30 days.
13. If your insurance mistakenly sends you our payment, please forward, the check immediately. Failure to do so may result in your account being turned over to a collection agency or small claims court.
14. If your insurance plan requires you have a referral, you must bring a copy of the referral with you to your appointments.
15. If you need a prescription refilled, contact your pharmacist. Please allow 24 hours for all prescription refills. PAIN MEDICATION WILL NOT BE REFILLED ON WEEKENDS.
16. We do not bill Auto Insurance or Third Party Liability Insurance. Payment will be expected at the time of service.
17. The insurance companies and Medicare's National Correct Coding initiative have determined that fracture care is performed as a global fee. This fee includes the physician's Evaluation and Management, application of the initial cast, rehabilitation guidance and overhead associated with this. Depending on your diagnosis, the insurance company allows a period of care from 1-90 days. This is called a "global period". Each visit during a "global period" does not include a physician's fee, but may include fees for x-rays, casting, and supplies, braces, etc. These guidelines are determined by national standards. Some insurance plans consider fracture care minor surgery; these claims may be processed using surgical benefits and may require additional payment for deductible and or- co-insurance.
18. There is a \$35.00 returned check fee. In the event of a returned check, please contact the billing department immediately.
19. There is a 1.5% interest charge on accounts outstanding past 30 days.
20. There is a \$5.00 charger per page form fee.
21. Copies of x-rays are charged at \$8.00 per film.
22. You may be charged a "no Show" fee of \$50.00 if you do not notify our scheduling office at least 24 hours prior to your appointment.
23. If you have compliance concerns, you can reach our office at compliance@metrocrest.com

Family members covered under the plan:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

I, _____, do hereby affirm that I have read and understand the above office policies. I hereby assign Metrocrest Orthopaedics & Sports Medicine all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) to issue payment directly to my treating physician for medical services rendered to me or my dependents regardless of my insurance benefits, if any. I authorize Metrocrest Orthopaedics & Sports Medicine to release medical information that may be necessary to request reimbursement from insurance companies to whom I have submitted a claim. I understand that I am responsible for all medical fees during my treatment with Metrocrest Orthopaedics & Sports Medicine. This assignment will remain in effect until revoked by me in writing. A photo copy of this assignment is to be considered as valid as the original.

Printed Name

Signature of Patient/Guarantor

Date

Signature of Patient/Guarantor

Date

Signature of Patient/Guarantor

Date

Signature of Patient/Guarantor

Date