Excelsior Orthopaedics, LLP
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# Patient Financial Policy/Consent Form
# Effective July 20, 2015

**Insurance Verification and Identification**
Patient is expected to present a valid insurance card and identification at each visit.

**Co-Payments and Past Due Balances**
All co-payments and past due balances are due and payable at the time of service. We accept cash, personal check, VISA, MasterCard, Discover and American Express. There is a service charge of $35.00 for returned checks. Patients with an outstanding balance over 90 days that have not made a payment arrangement may be sent to collection, prevented from scheduling future appointments or discharged from the practice. Unpaid accounts, including accounts with payment arrangements that are in arrears, will be turned over to a collection agency. If your balance is sent to collection, you will be responsible for all collection and attorney costs.

**Insurance Plan Participation**
We participate in most major insurance plans. A complete list is available upon request or on our website (www.excelsiorortho.com). It is the patients's responsibility to be aware of their insurance coverage, policy provisions and authorization requirements. Not all Excelsior providers participate with all insurance companies; please verify whether the physician accepts your insurance coverage when scheduling an appointment. If you provide our office with the necessary information needed to properly bill an insurance carrier that we do not participate with, we will submit a claim on your behalf. However, you are responsible for following up with your insurance carrier for unpaid claims and/or appeals. You are responsible for all deductibles, co-pays and non-covered charges.

**Self-Pay**
Self pay accounts shall exist if a patient has no insurance coverage. Payment in full is expected at the time of service--unless prior arrangements have been made with our Billing Department. If you need to discuss payment options, please contact our Billing Department at 716-250-6401, Monday-Friday, 8:00 a.m. – 4:00 p.m.

**Estimated Cost Quotes**
We will make every effort to estimate the cost of our services. Although we can not possibly predict all the services that may be required for an individual being treated in our office or having surgery, we will provide to you the name, practice name, address and phone number of any provider who is scheduled to perform anesthesiology, laboratory, pathology, radiology or assistant surgeon services in connection with care to be provided in our office or care that is referred by us. It's important to remember to contact the hospital, ambulatory surgery center, anesthesiology and any other physician offices that are involved in your care so that you understand your personal financial obligation.

**High Deductible Plans (Health Savings Accounts or Health Reimbursement Accounts)**
If your insurance is a High Deductible Plan, you will be required to pay a deposit prior to services being rendered. The deposit will be applied to your total cost. You will be billed for the balance owed or issued a refund for an overpayment.

**No-Fault/Workers Compensation**
You are responsible for providing our office with the necessary information (insurance carrier, claim #, date of injury, etc.) needed to properly submit charges. Without this information, the fees mandated by NY State will be changed to reflect our private fees and you will be responsible for payment. Some No-Fault carriers have deductibles on medical charges, for which

the **patient** (not the insured) is responsible. If you have private insurance we will submit on your behalf and bill you for any unpaid balances.

**Medicare Managed Care (PPOs, HMOs, etc.)**

You are responsible for remitting co-pays at the time of service and, unless otherwise indicated, responsible for obtaining the necessary referrals/authorizations your plan requires. These are provisions you agreed to when you contracted or signed up with your insurance plan. We will submit all charges and follow-up with your carrier for payment. You are responsible for all deductibles, co-pays and other non-covered charges. Failure to have the necessary referrals/authorizations your plan requires by the date and time of the appointment, may result in rescheduling the appointment.

**Medicare**

We are "participating physicians." This means we must accept Medicare's allowed charge for services rendered. Medicare will pay 80% of the approved amount. The patient is responsible for the remaining 20%, plus any out of pocket deductible. You will not be responsible for the difference between our full charges and what Medicare approves. If you have secondary insurance, we will submit the claim for the remaining balance after Medicare has paid. Please remember that although we accept Medicare, the patient, by federal law, must be held responsible for any portion of the approved amount not paid by Medicare or a secondary insurance company.

**Medicaid Managed Care (PPOs, HMOs, etc.)**

If you have a managed medicaid plan (Fidelis Care, Total Care, etc.) you are responsible for obtaining a referral from your primary care physician prior to services being rendered. Failing to have the necessary referrals/authorizations your plan requires by the date and time of the appointment, may result in rescheduling the appointment.

**Medicaid**

If you are seeing one of our providers that participates with Medicaid (not all providers do) you are responsible for providing our office with your ID# (begins with 2 alpha letters, followed by numerical digits and ending with 1 alpha letter).

**Referrals/Authorizations**

You are responsible for obtaining the necessary referrals/authorizations your plan requires. We must receive a referral 3 days prior to the date of service. Failing to have the necessary referrals/authorizations your plan requires by the date and time of the appointment, may result in rescheduling the appointment. If you do not provide the required referral or prior authorization and elect in writing to proceed with the appointment, the service or procedure you receive will be a Non-Covered Service under your plan, your visit for that date of service will be processed as self pay and payment will be due on that date.

**Liability**

Carriers usually remit payment to the patient or the patient's attorney if one has been retained. OUR POLICY DOES NOT ALLOW US TO HOLD ACCOUNTS WHICH ARE PENDING RESOLUTION OF ANY LIABILITY OR LITIGATION ISSUES. WE DO NOT, UNDER ANY CIRCUMSTANCES, BILL ATTORNEYS. If you provide a letter from the liability carrier indicating they accept full responsibility and will remit payment, we will submit claims for our charges on your behalf. Otherwise, you may either have charges submitted to your private carrier or pay for services and obtain reimbursement upon resolution/settlement.

**Custodial Parent Responsibilities**

The custodial parent is responsible for payment at the time of service whether the account is considered self-pay, participating insurances, or nonparticipating insurance. The office does not get involved with divorce specifics, e.g., one parent pays 80% and the other 20%. It is the parents' obligation to work out an agreement themselves or through the court system.

**Cancellation Fee**

A fee of $25 may be charged for any appointments missed or not cancelled before 24 hours of the scheduled visit. It is the patient's responsibility to notify the physician's office when an appointment needs to be cancelled or rescheduled.

**Records Fee**
Copies of medical records are available upon request. A fee of 75 cents per page will be charged for medical records.

**Imaging Fee**

Upon request, we will provide you with a copy of your images on CD. Additional copies will be provided but you will be required to be present in our office prior to preparation of the CD. You can expect a 10-15 minute wait for CD preparation.

**Forms Fee**
A fee of $10.00 is charged PRIOR to completion of disability forms. The $10.00 per form is applied to all disability forms with the exception of NYS Workers' Compensation and No Fault Insurance Carrier Forms. This fee is not covered by your insurance. You are responsible for payment. Failure to pay will result in the disability form not being filled out.

**Surgery Re-Scheduling Fee**
A fee of $50.00 may be charged for elective rescheduling of surgery unrelated to medical reasons.

**Cast Fees**
There are additional charges for customizing or waterproofing casts that can not be charged to your insurance. Any additional charges will be reviewed with you prior to performing the service.

**Durable Medical Equipment**
For your convenience, we offer braces, splints and other devices on site. Durable Medical Equipment's financial policies will be discussed with you should you require those services.

**Financial Hardship Policy**
Patients experiencing financial hardhship may apply for a discount or waiver of the patient's financial responsibility. Whether such a discount is granted shall be based on an individual assessment of the patient's financial circumstances. For a complete understanding of our Hardship Policy, please contact our Billing Department at 716-250-6401, Monday-Friday, 8:00 a.m. – 4:00 p.m.

**CONSENT/AUTHORIZATION FOR TREATMENT AND TO RELEASE/DISCLOSE PROTECTED HEALTH INFORMATION**

I hereby agree that Excelsior Orthopaedic, LLP may perform care and treatment, and may conduct such examinations, laboratory tests and procedures as may be directed by my physician or treating practitioner.

I hereby consent to the use and disclosure of my Protected Health Information by Excelsior Orthopaedic, LLP for purposes of treatment, payment and health care operations. For example, my physician or treating practitioner at Excelsior may furnish Protected Health Information maintained in the course of my care and treatment. Any release of my medical records and Protected Health Information will be made according to state and federal regulations. I understand that Excelsior may release medical information to any third party that may be responsible for payment of my medical expenses.

**ASSIGNMENT OF BENEFITS; INSURANCE PROCEEDS, SETTLEMENTS**

If I am entitled to health care services under any insurance policy from any person or organization that may become liable to me to provide such benefits, I assign such benefits to Excelsior Orthopaedic, LLP. I further authorize payment directly to Excelsior Orthopaedic, LLP and such physicians of all such insurance benefits payable to me. Such insurance may include, but is not limited to, priviate commercial insurance, auto liability insurance, worker's compensation and government programs such as Medicare and Medicaid.

I further assign to Excelsior Orthopaedic, LLP any payments for medical benefits payable to me as a result of any settlement or judgment in a lawsuit.

I certify that the information given regarding my insurance is accurate and current to the best of my knowledge.

Patient or Patient's Legal Representative: _____

Date: _____

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