Garden State Orthopaedic Associates Payment Policy

Thank you for choosing us as your orthopaedic care provider. We are committed to providing you with quality health care. This payment policy should answer your questions regarding patient and insurance responsibility for paying for our services. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in many insurance plans. If you are not insured by a plan with which we participate, payment in full is expected from you at each visit. If you are insured by a plan with which we participate, but don't have an up-to-date insurance card, payment in full from you for each visit is required until we can verify your coverage. If you don't have your referral form at the time of your visit, payment in full from you for each visit is due until we receive it. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. We accept MasterCard, Visa, Discover, cash and checks. If you do not have the co-payment at the time of your visit, we will charge you a $30 administrative fee in addition to the co-payment.

3. Non-covered services. Please be aware that some of the services you receive may be "non-covered" or not considered reasonable or necessary by your insurer. You will be held responsible for payment for these services.

4. Proof of insurance and referral forms. All patients must complete our patient information forms before seeing the medical provider. We must obtain a copy of your current valid insurance card as proof of your insurance. If you fail to provide us with the correct insurance information and/or referral form prior to your visit or procedure, you may be responsible for all or part of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly to the company. It is your responsibility to comply with their request. Please be aware that any portion of your claim that is not approved by your insurance company is your responsibility. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance may automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless you have entered into a written payment plan with us. We charge 1% monthly interest on all patient balances not paid within 30 days. Please be aware that if a balance remains unpaid beyond 90 days, we may refer your account to a collection agency. Failure to abide by this payment policy may result in you and members of your immediate family who are responsible for payment for your care being discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. If you request, we will make reasonable efforts to assist you in obtaining alternative care. During that 30-day period, our medical providers will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge $30.00 for missed appointments not canceled with a minimum of one business day's notice. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its terms:

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Signature of patient or responsible party **Date**
Relationship to responsible party:

_____

Print Patient Name **Acct Number**