PROSTHETIC
ORTHOTIC
INSTITUTE

Patient Financial Policy

Thank you for choosing Prosthetic and Orthotic Institute for your health care needs. The patient financial policy has been developed to assist in answering your questions regarding patient and insurance responsibility for services rendered. Your understanding of and compliance with our patient financial policy is important. Please read the policy below and ask the staff any questions you may have and sign as indicated. The original will be maintained in your file and a copy may be provided to you upon your request.

1. **PROOF OF INSURANCE:** All patients must complete our patient information form before seeing the physician. Prosthetic and Orthotic Institute participates with a large variety of insurance plans, including Medicare. Please confirm with our staff that we participate with your specific insurance plan. If you are not insured by a plan that we participate with, payment in full is expected at each time of service. It is your responsibility to ensure that we have your correct information and an up-to-date copy of your insurance card.

2. **UPDATED CHANGE OF INFORMATION & COVERAGE:** We will ask you to update this whenever you have a change in address, employment, insurance, etc. However, it is your responsibility to make us aware of these changes and if you fail to provide us with the correct updated information, you will be responsible for the entire cost of the services rendered and immediate payment will be expected.

3. **CO-PAYMENTS, DEDUCTIBLES & CO-INSURANCE:** All co-payments, deductibles & co-insurance must be paid at the time of service. Payment of your copayments, deductibles & co-insurance is part of your contract agreement with your insurance plan. Our failure to collect payment may be a violation of billing compliance and may be considered as an act of fraud by your insurance plan.

4. **NON-COVERED SERVICES:** Please be aware that some or perhaps all the services you receive may not be covered or considered reasonable or necessary by your insurance plans. If you elect to have these services, you will be asked to sign a waiver and payment in full at the time of service will be expected.

5. **REFERRALS:** Some insurance plans require a referral from a primary care physician to obtain services of a specialist, such as a prosthetics or orthotics. These health plans will not pay for services rendered without a referral. It is **'YOUR'** responsibility to obtain a referral prior to treatment. If you have not obtained the necessary referral, you may either reschedule your

appointment or, if allowed by your insurance company, sign a waiver agreeing to pay for the service at the time it is rendered.

6. **AUTHORIZATIONS:** Obtaining a prior authorization for services is not a guarantee of payment of benefits. A prior authorization means that the information given at that time meets the medical necessity for the services not a guarantee of payment. Your insurance plan will confirm to you that even though the services may be authorized, the services may not be covered under your plan and a decision for payment will not be rendered until a claim is submitted.

7. **CLAIMS SUBMISSION:** We will submit your claims and assist you in any way we can to help get your claims paid. Your insurance plan may request information directly from you. Your failure to timely comply to your insurance plan's request may result in your claim denial and if so, will result in our seeking full reimbursement from you for services rendered; even if we are a participating provider with your plan. Your insurance benefit is a contract between you and your insurance plan.

8. **SELF-PAY:** If you do not have valid health care coverage, you will be considered as self-pay. Payment in full is due at the time of service.

9. **PAYMENT METHODS:** We accept cash, personal checks, money orders, cashiers check, MasterCard, Visa and Discover as payment for services rendered.

10. **RETURNED CHECKS:** A returned check fee of $30 will be added to your account for every check returned for insufficient funds, stopped payment or closed accounts. After the second occurrence, only cash, money orders, cashier's check or credit card payments will be accepted.

*****Knowing your insurance benefits is your responsibility. Please contact your insurance plan with questions you may have regarding your coverage*****

This is an agreement between Prosthetic and Orthotic Institute and the patient/responsible party signed below. By executing this agreement, you are agreeing to pay for all services that are received.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY AND AGREE TO ABIDE BY ITS GUIDELINE.

Patient's Name: _____

Responsible Party: _____
(If not the Patient):

_____ _____

Signature of Patient or Respons