

UNITED REGIONAL PHYSICIAN GROUP
PATIENT PAYMENT POLICY

PAYMENT POLICY

Thank you for choosing us as your orthopaedic care provider. We are committed to providing you with the quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask 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 most insurance plans, including Medicare. If you are not insured by a plan we are contracted with, a payment of \$450.00 is expected at your visit. If you are insured by a plan with which we are contracted, but do not have an up to date insurance card, payment in full for each visit is required until we can verify your coverage. 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 deductible must be paid at the time of service. This arrangement is part of your contract with your insurance company.
3. **NON-COVERED SERVICES:** Please be aware that some –and perhaps all – of the services provided may be non-covered or not be considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. **PROOF OF INSURANCE:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **CLAIMS SUBMISSION:** We will submit your claims and assist you in any way within contract limitations. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance coverage 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 within 60 days, the balance will automatically be billed to you.

7. **NON PAYMENT:** Please be aware that if a past due balance remains unpaid; we may refer your account to a collection agency.
8. **MISSED APPOINTMENTS:** Please help us serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for your understanding our payment policy. Please let us know if you any questions or concerns.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY AND AGREE TO ABIDE BY ITS GUIDELINES:

Signature of patient or responsible party

Date