TOCA PATIENT FINANCIAL POLICY

The team at **THE ORTHOPEDIC CLINIC ASSOCIATION** is pleased to be a part of your medical experience, and we thank you for choosing us. We believe that communication is the key to a successful partnership in your care**.**

Please read and initial that you understand the following statements;

- It is my responsibility as an insured patient to be aware of any restrictions or requirements stated in my insurance policy. These include deductibles, second opinions, and policy exclusions or waived benefits, precertification, and inpatient vs. outpatient benefits restrictions**._____(Initial)**

- My appointment may be rescheduled if I do not have my insurance card, valid ID, referral, co-payment, and/or I am late for my arrival time. **_____(Initial)**

- I will be responsible for paying my deductible or coinsurance in full prior to any surgery and/or procedure. The amounts given prior to surgery are an ESTIMATE only. The amount may change as additional services may be rendered by my physician as deemed necessary for my care.**_____(Initial)**

- If I require pre-operative testing, such as blood work, EKG, chest x-ray, etc., these tests may not be approved by my insurance (such as Medicare) and therefore ***may not*** be covered. I will be responsible for the charges if this applies to me. **_____(Initial)**

- It is my responsibility to pay all Co-Pay, Co-Insurance, Deductible, Self-Pay amounts, and past due balances at the time of my service(s). **_____(Initial)**

- It is my responsibility to pay all uncovered services after my insurance has paid their portion**. _____(Initial)**

- **I understand a $35 fee** will be added to my account for any returned checks. Once a check has been returned, I will be required to pay via cash or credit card.**_____(Initial)**

- **I understand a $25** fee will be collected from me prior to release of my completed disability and FMLA forms. **_____(Initial)**

- If I am a **self-pay patient**, I will be expected to pay **$200 for a non-fracture** prior to being seen or **$400 for a fracture** and the remainder of the balance at the end of my visit. If I do not pay the full amount at the time of service I will not receive the time of service discount. **_____(Initial)**

- If my account is not paid in full within 90 days of my first statement I may be turned over to collections. If my account is turned over to collections an additional 25% processing fee will be added to the outstanding balance. **_____(Initial)**

- **I understand** I may be charged a fee for not showing up to office visits and/or surgeries. **_____(Initial)**

I understand and I have read the above Financial Policy and I agree to abide by its terms.

Patient or Guarantor Name: _____ **Relationship**: _____

Patient Signature: _____ **Date:** _____