Patient Financial Responsibility Policy

Orthopedic Associates of Lancaster, Ltd (OAL) appreciates the confidence you have shown in choosing us to provide for your orthopedic needs and we are committed to providing you with the best possible care. The medical services you seek imply a financial responsibility on your part. Your clear understanding of our Financial Policy is important to our professional relationship. Please feel free to ask if you have any questions regarding your financial responsibility.

Our receptionist may ask to see your insurance card at every visit and will scan your card into our system as needed to keep our information current and to facilitate accurate insurance billing.

Co-Payments: Your insurance plan determines your co-pay and they require that we collect your designated co-payment at the time of service. Please be prepared to pay the co-payment at each visit. If you are unable to pay your co-payment at the time of your visit, you will be charged a $5.00 fee.

Self Pay: You will be considered self pay if you have no insurance coverage. Payment is expected at the time of service. A $100.00 deposit is required at the beginning of your appointment with the balance to be paid after. If you are unable to pay the balance in full, you will be required to meet with the Business Office to determine payment options.

Non-Participating Insurance Plans: As a courtesy to our patients, OAL will bill your non-participating insurance plan. Any outstanding balances are the responsibility of the patient.

Referrals: If your insurance plan requires a referral from your Primary Care Physician, **it is the patient's responsibility** to obtain your referral prior to your appointment and to have it with you at the time of your appointment. If you don't have the referral, **YOU MAY BE REQUIRED TO RESCHEDULE.**

Automobile Accident/Worker's Comp Cases: Patients shall be financially responsible for medical services related to automobile/workers' comp. It is the responsibility of the patient to notify OAL of the date of injury, claim #, insurance company address, phone number and contact person. If your motor vehicle claim exhausts, or your worker's comp claim denies, it will be the patient's responsibility to submit to OAL any other insurance plan that you may have, or the charges will be considered the patient's responsibility. If your insurance plan is a non participating plan with OAL and your motor vehicle exhaust or worker's comp denies, you will be responsible for any unpaid charges.

Medicare: OAL will submit your claim to Medicare and upon receipt, will bill your secondary insurance if one applies. The patient will be responsible for the deductible and the co-insurance, if you do not have a secondary insurance.

Non Covered Services: As part of your treatment your physician may prescribe Durable Medical Equipment (DME). OAL will make every effort to authorize this service (if needed) with your insurance company. In the event that your insurance company denies this item, or you do not have DME benefits, you will be responsible for any balances. **Durable Medical Equipment is non refundable and may not be returned.**

Child Custody Cases: The parent that signs for services will be responsible for all outstanding charges.

Disability/FMLA/Insurance Forms: Each form requires a $15.00 pre-payment before the form(s) will be completed. These forms take 7-10 business days to complete.

Returned Check Fee: Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being assessed a $25.00 fee per check returned.

Financial Responsibility of Patient: I understand that if I do not make payment for services owed, OAL will take all necessary and appropriate action to collect any money due from me to OAL, but not limited to the use of collection agencies, or attorneys. I will be responsible for any and all fee associated with these collection efforts

WE ACCEPT CASH, MASTERCARD, VISA, DISCOVER AND CHECKS.

I hereby authorize OAL to release all medical information to insurance carriers and or Centers for Medicare/Medicaid concerning my illness and treatment and I hereby assign payment to OAL for services rendered to myself/my dependent. I understand **I AM RESPONSIBLE FOR ANY AMOUNTS NOT COVERED BY MY INSURANCE.**

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Signature of Patient, Power of Attorney, or Guardian if minor Date