

**THE CARDINAL ORTHOPAEDIC INSTITUTE**

**PATIENT FINANCIAL POLICY**

We are committed to provide you with the best possible orthopaedic care, and will work with you to meet any special needs you might have. However, that requires that both the patient and physician understand what is expected of the other, medically and financially.

The following information is an agreement between The Cardinal Orthopaedic Institute and Patient/Responsible Party named below. By signing this agreement, you are acknowledging that you understand our insurance and financial policies and are agreeing to pay for all services that are received.

***Insurance Participation***

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Our office participates in a variety of insurance plans, and we will submit all claims to those carriers. However, there are several points we wish to emphasize:

- Your policy is a contract between you and the insurance company. While we will assist as much as possible, it is your responsibility to be familiar with your coverage and contact them directly if you have questions.
- You must bring your insurance card with you to every visit, and make us aware of any changes in coverage.
- You are expected to pay your copayment at each visit. If you ask us to bill you for this amount, or decline to pay on the date of service, there will be a \$10.00 processing charge added to your account.
- If we do not participate with your insurance, you will likely have a higher out-of-pocket expense, so please be prepared.

***Self-Pay Patients***

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If you do not have insurance, you will be asked to pay your balance at the time of your visit. Should you schedule elective surgery, we require that 50% of the estimated fees be paid at least one week prior to surgery, or the surgery will likely be canceled.

***Payment Arrangements***

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If you need to arrange a payment plan, please ask for someone to assist you while you are in the office. Based upon your total balance, we may offer limited payment terms.

***No-Show Charge***

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If you are unable to keep your appointment, and do not provide at least 24 hours notice of cancellation, you may be subject to a \$25 charge.

***Minors***

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If the patient is under age 18, the parent or guardian must sign below. If the minor does not reside with both parents, and there is a dispute over which parent is responsible for any bills, we will ultimately rely upon the parent/guardian who brought the child to the office for financial responsibility.

***Past Due Accounts***

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If your balance is not paid in a timely manner, we reserve the right to forward your account to an outside collection agency or attorney. All fees assessed by the agency or attorney will be charged to you and become part of your outstanding balance.

**I HAVE READ, UNDERSTAND AND AGREE TO COMPLY WITH THESE POLICIES.**

Date: \_\_\_\_\_ Name: \_\_\_\_\_  
Print Name of Patient

Signature: \_\_\_\_\_  
Signature of Patient or Responsible Party

# THE CARDINAL ORTHOPAEDIC INSTITUTE

## ***CONSENT TO THE USE/DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS***

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This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights and responsibilities with respect to your health care information.

The Notice of Privacy Practices provides more detailed information about how The Cardinal Orthopaedic Institute may use and disclose health information. I have the legal right to review the Notice of Privacy Practices before I sign this consent, and The Cardinal Orthopaedic Institute encourages reading it in full. My signature below verifies that I have received the Notice of Privacy Practices. I understand that the terms of the Privacy Notice may change, and I may obtain these revised notices by contacting the practice by phone or in writing. I have the right to request how my health information is used and disclosed. I also have the right to restrict how this information is disclosed, but the practice is not legally required to agree to these restrictions. The Cardinal Orthopaedic Institute must receive requests for any restriction of disclosure in writing.

I hereby authorize The Cardinal Orthopaedic Institute to release any information acquired in the course of my examination or treatment for the purposes of treatment, payment and healthcare operations. This information may be delivered in person, via regular mail, modem, telephone, or facsimile transmission. The information may be viewed by someone other than the intended recipient and I hereby release The Cardinal Orthopaedic Institute from any liability as a result of such transmission.

I have been informed and understand that The Cardinal Orthopaedic Institute will not bill third party payors (automobile/homeowners or other business insurances). I understand that all charges accrued by me must be submitted to my private health insurance, and third party payors must settle privately with these individuals. I further understand that any unpaid balance is my financial responsibility.

I understand that I may revoke this consent in writing, but the revocation will not apply to any services given before the revocation was signed. I also understand that by refusing to sign this consent or revoking this consent, this practice may refuse all services.

### **CHECK ONE:**

I authorize payment of surgical and/or medical benefits directly to The Cardinal Orthopaedic Institute. I understand I am financially responsible for all charges not covered and guarantee payment of this account

### **OR**

For the following reasons, I agree to be responsible for all bills incurred in the course of my examination and treatment

- No insurance coverage in force at this time.
- I do not wish to have The Cardinal Orthopaedic Institute bill my insurance company for me.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date