Hand Microsurgery and Reconstructive Orthopaedics, LLP
Financial Policy

Thank you for choosing us as your health care provider. We are committed to your successful treatment. Please understand that payment of your bill is considered part of your treatment. The following is our Financial Policy that we require you to read and sign prior to any treatment. All patients must complete this form before seeing the provider.

PAYMENT IS DUE AT TIME OF SERVICE UNLESS ARRANGEMENTS HAVE BEEN MADE TO BILL YOUR INSURANCE CARRIER. WE ACCEPT CASH, CHECKS , VISA/MASTERCARD, DISCOVER and CARE CREDIT.

REGARDING YOUR INSURANCE:

Please remember that insurance is considered a method of reimbursing the patient for fees paid directly to the provider and **is not a substitute for payment.** While the filing of insurance claims is a courtesy that we extend to our patients, **all charges are your responsibility.** It is the patient's ultimate responsibility to pay any deductible amount, co-insurance or balance not paid for by your insurance company. If we are filing your insurance claim we will allow 45 days for processing and payment from your insurance carrier. If payment is not received within 45 days we will notify you to pay your account in full and seek reimbursement from your insurance carrier. In the event your account becomes delinquent it will be assigned to a collection agency. The patient agrees to pay all costs of collections including any court costs, sheriff or attorneys fees, and collection fees. **ALL COPAYS AND DEDUCTIBLES ARE DUE AT TIME OF TREATMENT. IN THE EVENT THAT YOUR INSURANCE IS NOT A PLAN WE PARTICIPATE WITH REFER TO THE ABOVE PARAGRAPH.**

REGARDING WORKERS COMPENSATION:

If you are a patient with a valid Workers Compensation claim, we will bill your workers comp carrier for reimbursement on all treatment rendered. Patients whose claims are denied by Workers Compensation must pay their balance due within 45 days or provide our office with private insurance coverage to bill**. Please bear in mind that simply filing a claim with a Workers Compensation carrier does not guarantee acceptance or payment of your medical bills**. We must emphasize that it is YOUR responsibility to ensure that your employer has filed your claim and all information required by the carrier has been received.

REGARDING MEDICARE:

Hand Microsurgery will bill Medicare and your supplemental insurance company as a courtesy to you. Medicare will pay 80% directly to us, and the other 20% must be collected from the patient or supplemental insurer. If you do not have supplemental insurance, this 20% would be your responsibility.

USUAL AND CUSTOMARY RATES:

Our practice is committed to providing you with the best possible care and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of rates.

CONSENT FOR MEDICAL TREATMENT:

The undersigned hereby consents to any treatment or services rendered under the general and special instructions of the physician assigned to care for me. I also acknowledge that there is no guarantee of treatment outcomes or results.

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION:

Hand Microsurgery and Reconstructive Orthopaedics, LLP is hereby authorized to disclose all or any part of the medical record of the patient named on this registration to such insurance companies or agencies as may be concerned with the payment of professional and/or facility costs of said patient.

NOTICE OF PRIVACY PRACTICES:

Our Notice of Privacy Practices is posted in the waiting room of our facility. We will supply you with a copy upon request.

I certify that I have read and understand fully the providers **Financial Policy** and have read the **Notice of Privacy Practices** and may request a copy for my records. I agree to make payment in full and/or satisfactory arrangements when asked to do so as specified above. I authorize and direct my insurance carrier(s) to issue payment(s) directly to Hand Microsurgery and Reconstructive Orthopaedics, LLP for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

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Signature of Patient or Responsible Party Date