Granite Orthopaedics: Financial Policy

In today's financial climate we understand that patients must be efficient with their money and that you, as a patient and a consumer, have options in Yavapai and Coconino County healthcare communities. In order to help keep your cost down, we are making a concerted effort to run as financially efficient of an office as we possibly can. To do this, we strictly abide by the following guidelines: ***PLEASE INITIAL EACH SECTION***.

______ 1. Payment is due at the time services are rendered. Our staff will provide you with accurate information as available to us from your insurance company regarding your co-pay, deductibles and coinsurance amounts. Balances that are residual after filing with your insurance company will be expected prior to your next scheduled office visit or statement date whichever is sooner. **We highly recommend that you read your insurance booklet or call your insurance company requesting benefit description for a specialist office**. This will provide you with some basic information prior to your visit. If the patient is unable to pay at the time of service, the appointment may be rescheduled, or the patient may opt to bring payment before the end of the business day. If this is not paid at that time no other appointments will be scheduled until it has been paid in full.

______ 2. **FEES**: **Returned check fees – $35.00**

______ 3. Should you default on your balance, Granite Orthopaedics has the right to discharge you as a patient, not accept new diagnosis, and/or refuse future appointments until balance is paid in full. It is the patient's responsibility to set up a payment plan with Granite Orthopaedics billing department if needed. If your account becomes delinquent, please be aware you will be responsible for any collection fees, legal expenses, and court costs necessary to recover the delinquent balance.

______ 4. Private pay/ uninsured patients will be given a **Good Faith Estimate** (**estimate of the total expected costs of non-emergency healthcare items or services**). A Good Faith Estimate intends to offer predictability & transparency in how much clients will be charged for healthcare services prior to their appointment. These patients do receive a discounted rate, calculated off of Medicare allowable for all procedure codes and evaluation codes. Unfortunately, our contracts with insurance companies do not allow us to negotiate prices or provide an additional discount in any manner for those individuals with insurance.

______ 5. You will be responsible for promptly responding to your insurance company to provide any additional information they may request regarding your treatment, pre-existing conditions, accidents, or prior medical coverage. Failure to respond in a timely manner may result in your account becoming due and payable, in full, immediately.

______ 6. SURGERY/ FRACTURE CARE – We understand that surgeries and fractures are usually not calculated into the patient's regular budget; unfortunately, we are bound to our insurance contracts to collect co-pays, deductibles, and coinsurances. This is expected prior to surgery and our surgery scheduler will contact you to give you the estimated total. Again, this is only an estimate as to what your insurance will pay and what you will owe. Fractures may be considered surgery by your insurance company. They are technically closed treatments of a broken bone

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instead of the traditional view of surgery, an open treatment of a fracture. To avoid confusion "breaks" "fractures", and "cracks" are all classified as fractures and are coded the same by your insurance company.

______ 7. THIRD PARTY PAYORS/ LETTERS OF PROTECTION – Granite Orthopaedics does not take third party insurance or operate under letters of protection. If you should still desire care at our facilities, we are able to classify this as self-pay and payment in full is due at the time of service.

______ 8. WORKERS' COMPENSATION – We will happily treat your work-related injury. You must have a claim number and workers' compensation contact information prior to scheduling and appointment. If you are unsure as to whether this is a work injury or not, please discuss it with your employer *prior* to scheduling an appointment. There is a **$50.00 transfer fee** for each visit filed with insurance that needs to be converted to worker's compensation.

______ 9. MINORS – Individuals under 18 will be rescheduled should they not have a parent's permission from signed and payment for that date of service.

______ 10. We can supply you with Durable Medical Equipment in our office should your injury require it. Some items are billed through an outside company. If any item is provided by our office, you will be asked for a DME Deposit. Durable Medical Equipment is most often applied to your deductible and coinsurance. This deposit will be applied to this amount, and you will be billed for any remainder. Insurances do not cover some small items and in that instance payment in full will be expected at the time you receive the item. It is necessary for us to have you sign a DME waiver in case your insurance denies coverage of the item.

______ 11. I (the patient) authorize my insurance benefits to be paid directly to the physician, and that I am financially responsible for any balance(s). I also authorize Granite Orthopaedics or the insurance company to release my information required to process my claims.

______ 12. DISCLOSURE OF OWNERSHIP: Your physician may have ownership in one or more medical entities to which you may be referred. If you would like to see a list of the businesses in which your physician has financial interest, and to which you have been referred, please request this from our office. Some of these businesses may be out of network pertaining to your insurance. You have the right to choose the provider of your health care services. Therefore, you have the option to use another service provider or facility. You will not be treated differently by your physician should you choose or request another option. Please feel free to ask your physician or staff if you have any questions or concerns regarding this notice. By initialing and signing this disclosure, you acknowledge that you have read and understand the foregoing notice.

Patient Name (**Please Print**): ____________________________________ **DOB**: ________________________

Patient Signature: ____ **Date**: ________________________