CENTTRAL FLORIDA BONE AND JOINT INSTITUTE
FINANCIAL POLICY

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

REGARDING INSURANCE

MEDICARE – We accept Medicare assignment. We also accept SOME Medicare Replacement plans. Please check with the Receptionist before seeing the doctor to make sure your Replacement plan is one that we accept. This means that we have agreed in contract to accept the fees and bill according to Medicare allowed amount. The patient is responsible for the annual deductible and 20% of the approved amount at the time of service except when there is a supplemental policy to pay these amounts.

MEDICAID – We only accept certain Medicaid insurances. Please check with the Receptionist before seeing the doctor to make sure your Medicaid plan is one that we accept.

SHARE OF COST – It is our policy that the patient will be responsible for any charges incurred at the time of service. Upon payment, a receipt will be given with detailed charges that can be turned into the case worker for reimbursement.

PRIVATE INSURANCE – It is the **patient's responsibility** to verify with the receptionist that their insurance is one that we accept prior to seeing the doctor. Failure to do so will make the patient responsible for 100% of the charges incurred. All co-pays, deductibles, and co-insurances are due at the time of service. In the event that there is a remaining balance on your account after insurance has paid, payment is due within 30 days of the insurance payment. If payments are not made within 30 days of the insurance payment, then the account may be submitted for collections. The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between yourself and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance policy contract.

REFERRAL/AUTHORIZATIONS – In that we are out of network with insurance plans that require referrals and/or authorizations, you will be responsible for all charges at the time of service. Your insurance will be billed out of courtesy if a written authorization is obtained. **You are responsible for obtaining any authorizations necessary for your visit or testing prior to the date of your appointment.** Authorizations must be in **writing** from your PCP or authorized insurance representative. You will be responsible for charges if **written** authorization has not been obtained prior to the date of service.

SELF PAY - If you do not fall within any of the categories above, we require **FULL PAYMENT AT THE TIME OF SERVICE**. You will be considered a Self Pay patient and upon the first visit required to pay the advance amount of $250.00 We **DO NOT ACCEPT** checks or partial payments for your first visit. After the first visit you may pay by cash, check, Carecredit, Visa, Discover or Mastercard. If there are any additional charges you will be asked to pay the remaining balance at checkout, if applicable. Please be advised that the $250 initial payment is only an estimate and charges may be more than $250 depending on the services received.

SURGERY PATIENTS – It is the patient's responsibility to check **PRIOR** to surgery to make financial arrangements for surgery costs that exceeds $500.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients 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 usual and customary rates.

For your convenience we accept **CASH, CHECKS, CARECREDIT, AND CREDIT OR DEBIT CARDS**.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Patient's Name (please print)__________________________________ Date ____________________________

Patient/Responsible Party's signature____

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