Authorization and Consent for Treatment

Assignment of Benefits and Authorization to Release Medical Information

I authorize and understand that payment of benefits under Medicare, Medicaid, and/or any other insurance company, will be made on my behalf to the provider, for services furnished to me by that provider. I authorize any holder of my medical information to release it to Washington Circle Orthopaedic Associates P.C., a Division of the Centers for Advanced Orthopedics, LLC, the Health Care Financing Administration, listed insured and/or agents of the company and/or the listed responsible person(s), any information needed to determine these benefits or the benefit for the related services. In the event that my insurance plan is out of the Washington Circle Orthopaedic Associates P.C., a Division of the Centers for Advanced Orthopedics, LLC network, or if I am a self-pay patient, assignment of benefits may not apply. I certify that the information I have reported with my insurance coverage and demographics is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Guarantee of Payment and Pre-Certification

In consideration of services rendered to the patient named herein, I agree to be financially responsible and to pay charges for all services ordered by the provider. I understand that any balance due as a result of being uninsured or under-insured is payable immediately. I further understand that if I fail to maintain consistent payments, my account will be referred to a collection agency and or attorney, & I agree to pay all collection of related charges.

I understand that if my insurance has a pre - certification or authorization requirements, it is my responsibility to notify the carrier of services rendered according to the plan's provisions. I understand my failure to do so will result in reduction or denial of benefit payment and I will be responsible for all balances.

I acknowledge that I have received the financial policy and agree to abide by its terms.

Consent for Treatment

I voluntarily consent to the rendering of such care as the provider(s), in their judgment, deems necessary for my health and wellbeing**.**

This consent shall include medical examination and diagnostic testing as well as minor surgical procedures (Including suturing, injection and/or aspiration), cast application/removal and shall also include the carrying out of the orders of my treating provider by office personnel. I acknowledge that neither the provider nor the office personnel has made any guarantee or assurance as the results that may be obtained.

I certify that I have read and understand this consent.

Consent to Call

As a component of my care, I understand and agree that Washington Circle Orthopaedic Associates P.C., a Division of the Centers for Advanced Orthopedics, LLC may contact me using phone calls to my landline or calls and emails sent to my mobile device. These communications may notify me of test results, treatment recommendations, outstanding balances, or any other communication from the medical group.

I certify that I have read and understand this consent.

➤ **Signature:**_____

Date:_____ *To be signed by parent or legal guardian if the patient is a minor under the age of 18, or a mentally incompetent patient.*

Financial Policy

Welcome to Washington Circle Orthopaedic Associates P.C., a Division of the Centers for Advanced Orthopedics, LLC. We are pleased that you have chosen us as your care provider. Our mission is to provide you with the highest level of professional medical care with the highest degree of patient satisfaction. One important aspect of optimal patient care is to have an agreement as to financial responsibility to avoid any misunderstandings and to ensure timely payment for services.

Washington Circle Orthopaedic Associates P.C., a Division of the Centers for Advanced Orthopedics, LLC (WCOA) policy requires that all patients sign the Authorization and Consent for Treatment Form prior to receiving medical services. The form confirms that patients understand services being provided are necessary and appropriate. The form also advises patients of their complete financial responsibility for all medical services received without regard to insurance eligibility or coverage determinations.

Payment Responsibility

Patients or their legal representative are ultimately responsible for all charges for services rendered. Payment is expected at the time of service for all charges owed for the current visit as well as any prior balance.

Post-operative visits for which you require additional services beyond the scope of the follow-up exam, (i.e. x-rays, casting, aspiration) an additional charge will be incurred and you will be asked to pay resulting additional copayments or patient responsibility amounts.

All services rendered to minor patients will be billed to the accompanying adult. In cases of large patient balances, payment plans are available. Ask to speak to the office or billing manager to make payment arrangements. Please don't hesitate to ask, we are here to help.

TYPES OF PAYMENTS

Co-payments: WCOA is required by insurance carriers to collect co-payments at the time services are rendered. The patient's appointment may be rescheduled if he/she is not prepared to make this payment.

Deductibles: Some insurance plans require patients to pay a predetermined amount before services will be covered.

Co-insurance: Some insurance plans require that patients pay a predetermined percentage (e.g. 20%) of the allowed charge amount.

Uninsured Patients (Self-Pay): Payment for all services rendered is due at the time of service. Patients paying the total of the charges for that days visit will be given a prompt pay discount.

New patients: Total charge or a minimum $200 deposit.
Established patients: Total charge or a minimum $150 deposit.
Uninsured patients having a procedure The patient will be required to pay the total amount of the anticipated charges or a minimum of 50% to the providers' office prior to the procedure being performed.

Out-of-Network: Patients being seen as Out of Network will be required to pay a payment for that days visit at the time services are rendered. We will courtesy bill your insurance company.

New patients: Total charge or a minimum $200 deposit.
Established patients: Total charge or a minimum $150 deposit.

Non-Covered: “Non-covered” means that a service will not be paid under a patient's insurance contract. If a patient is unsure whether a service is covered by his/her plan, it is ultimately the patient’s responsibility to call his/her insurance carrier to determine what the schedule of benefits allows. If non-covered services are provided, the patient will be expected to pay for the services at the time of service. Appeal procedures are generally available and billing staff will assist patients in attempting to resolve adverse determinations. Under no circumstances will billing staff falsify or change a diagnosis or symptom in order to ensure that a service will be covered.

Insurance

The patient's insurance is a contract between him/her (and/or employer) and the insurance carrier. Washington Circle Orthopaedic Associates, P.C., a Division of the Centers for Advanced Orthopedics, LLC, is not a part of this contract for this reason, we will not waive co-pay or deductible. Before your visit, it is your responsibility to contact your insurance company to verify the physician you are scheduled with participates with your plan and that the services that you intend to receive are covered. In addition, because some insurance plans require either precertification and/or a referral from a primary care provider before a procedure can be performed, please ask if these are required and obtain them if necessary. Please reference tax identification number 454852156 in addition to the physicians name when contacting your insurance company.

All patients must present their insurance card (if applicable) and proof of identification (e.g. Photo ID/Driver’s license) at every visit and communicate any changes in your personal contact information. Patients who do not provide current proof of insurance will be billed as a self-pay patient. If at a later time the patient presents his / her insurance card(s), services already rendered may or may not be retroactively billed depending on the insurance’s claim filing requirements.

Patients are responsible to:

- Know if they are using in or out-of-network benefits if they have a dual policy.
- Check with their insurance carrier to determine if prescribed testing/service is covered under their medical policy. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain Services they will not cover. (If patient chooses to have non-covered testing/service, payment in full at the time of service will be required.)
- Contact the insurance carrier to determine the schedule of benefits and if a co-payment or deductible applies.
- Arrive for appointments with proper documentation.
- Assist in appealing adverse determinations.

Insurance Verification. Verification of patient’s Insurance eligibility will be done electronically through the practice management system. If staff members are unable to confirm active insurance coverage for a patient, the patient will be informed and an alternative form of active insurance coverage will be requested. If the patient is unable to present active insurance coverage at the time of service they will be classified as self pay and will be required to pay at the time services are rendered or may reschedule their appointment without penalty.

Insurance Claims Processing. Washington Circle Orthopedic Associates P.C., a Division of the Centers for Advanced Orthopedics, LLC, accepts assignment of benefits for many insurance carriers. In accordance with the insurance carrier contracts patients will be required to pay co-payments at the time service are rendered. Washington Circle Orthopedic Associates P.C., a Division of the Centers for Advanced Orthopedics, LLC will submit charges for services rendered to the insurance carrier the patient or guarantor will be expected to pay the entire amount that is determined to be patient responsibility. These fees are for Physician Services only and there may be additional bills from laboratory or other diagnostic related procedures (blood work, MRI, CT, etc), if these services are recommended and performed outside of the office.

Non-contracted Insurance. If non-contracted “out-of-network” insurance (an insurance company with which our providers are not contracted) has not paid within thirty (30) days, the remaining balance, beyond the amount we collected at the time of service, is the patient’s responsibility.

Outstanding Balances

Any outstanding balance that is due from the patient is payable in full upon receipt of the statement. In the event a patient presents for an office visit and has an outstanding balance, a request for payment will be made. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us for assistance in the management of your account.

Statements are generated on a 28-day cycle. Patients who fail to respond to statements will be placed into a collection status. Patients with an outstanding balance for more than 90 days may be referred to an outside collection agency. If your account is turned over for collection action all applicable fees will be the patient/guarantor's responsibility.

A patient with unpaid delinquent account or an account that has been written off as a bad debt may not receive additional scheduled services unless special arrangements have been made. The patient may be discharged from the practice, however, in all situations the urgency of treatment will be taken into consideration.

Late Arrivals, Cancellations, No-shows and other fees/policies

Late Arrivals. Patients who arrive late for a scheduled appointment may be asked to reschedule the appointment or wait for an open appointment time on that days schedule. The Physician may decide to work the patient in but this is at the discretion of the physician.

Cancellations. Patients shall call at least one business day in advance if unable to keep a scheduled appointment time or surgery or the practice will consider the patient a "no-show".

There is a **$200.00** fee for a procedure or surgery that is not cancelled 3 days in advance. This fee will need to be paid prior to rescheduling. This fee cannot be billed to insurance.

No-shows. Patients who do not present for a scheduled appointment will be considered a no-show. These patients may be charged a **$50.00** fee for a missed appointment and a **$200.00** fee for a missed procedure or surgery, which needs to be paid prior to rescheduling. This fee cannot be filed to insurance.

No shows will be documented in the practice management system and a history of no-shows may result in refusal to schedule future appointments. Washington Circle Orthopedic Associates P.C. staff will notify the patient by regular mail when this decision is made.

Forms. There will be a minimum fee of **$40.00** for the completion of any form other than that required by your health insurance for payment to this office for medical services (e.g. FMLA, short or long term disability forms). Please allow 2 to 3 weeks for completion of all forms. There is a fee of **$25.00** for the completion of a handicap parking application.

Lost prescriptions/referrals. There will be a **$15.00** fee, payable at the time of request, for the reproduction of any lost referrals or prescriptions for physical therapy, medications and radiology exams.

It is the responsibility of the therapist to request a renewal prescription for continued treatment before your next appointment. If you are at the physical therapy office and need a continuation of therapy prescription faxed immediately there will be a **$15.00** fee payable at the time of request.

Refills. Doctors are not always present when refills are requested. Please allow 2 to 3 business days for refill requests to be processed. There will be no refills authorized after 11 a.m. on Fridays.

Medical Records. Please allow up to 2 weeks for completion of medical record requests, with a charge of **.50** cents per page, paid in advance. Please allow up to 5 business days for completion of X-ray copy request, with charge of **$15.00** to be paid in advance.