

## **PATIENT FINANCIAL RESPONSIBILITY STATEMENT**

Thank you for choosing Orthopedic Associates of Port Huron, P.C. as your healthcare provider. The medical services you seek imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, we ask that you read and sign this form. Feel free to ask if you have any questions regarding your financial responsibility. If someone else (parent, spouse, domestic partner, etc.) is financially responsible for your expenses or carries your insurance, please share this policy with them, as it explains our practices regarding insurance billing, copayments, and patient billing. By signing below and/or by receiving medical services from Orthopedic Associates of Port Huron, P.C. ("Orthopedic Associates"), you agree:

1. You acknowledge and agree to the FINANCIAL POLICIES of Orthopedic Associates. You may view the current version online at [www.oaph.com](http://www.oaph.com) or request a copy from the Business Office Staff. These policies may be changed from time to time by Orthopedic Associates, without notice. If there is any conflict between the FINANCIAL POLICIES and this PATIENT FINANCIAL RESPONSIBILITY STATEMENT, the FINANCIAL POLICIES shall control.
2. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, coinsurance amounts or any other patient responsibility indicated by your insurance carrier or our FINANCIAL POLICIES, which are not otherwise covered by supplemental insurance.
3. You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: (i) your health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at Orthopedic Associates, and you have not obtained such an authorization or referral; (ii) you receive services in excess of such authorization or referral; (iii) your health plan determines that the services you received at Orthopedic Associates are not medically necessary and/or not covered by your insurance plan; (iv) your health plan coverage has lapsed or expired at the time you receive services at Orthopedic Associates; or (v) you have chosen not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.
4. You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting verification of current insurance and paying any co-pays or other patient responsibility amount at each visit. Your card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be treated as a self-pay patient. As a self-pay patient, our fee is expected to be paid in full at the time of service. If the insurance card or other necessary information is furnished after the visit, we may file a claim with your insurance; and, if paid in full by your insurance, you will be reimbursed. If you are not prepared to make your co-pay or other patient responsibility amount, your visit may be re-scheduled by Orthopedic Associates.

5. We may verify your insurance benefits or submit your claim to your insurance carrier as a courtesy to you. You agree to facilitate payment of claims by contacting your insurance carrier when necessary. Without waiving any obligation to pay, you assign to Orthopedic Associates, for application onto your bill for services, all of your rights and claims for the medical benefits to which you, or your dependents are entitled, under any federal or state healthcare plan (including, but not limited to, Medicare or Medicaid), insurance policy, any managed care arrangement or other similar third-party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to you. You authorize Orthopedic Associates and associated physicians, staff, and hospitals to release patient information acquired in the course of your examination and/or treatment including but not limited to any and all medical records, notes, test results, x-ray reports, MRI reports or other documents related to your treatment (including itemization of any charges and payments on my account) that is deemed necessary to process this claim to the necessary insurance companies, third party payors, and/or other physicians or health care entities as they require to participate in your care. It is important to notify us as soon as possible of any changes related to your insurance coverage. Failing to do so may result in unpaid claims, and you will be responsible for the balance of the claim. Orthopedic Associates does not accept responsibility for incorrect information given by you or your insurance carrier regarding your insurance benefits or benefit plans.

6. If your insurance carrier does not remit timely payment on your claim, you will be responsible for payment of the charges within the terms set forth herein. Once your insurance carrier processes your claim, we will bill you for any remaining patient responsibility deemed by your insurance carrier. If any payment is made directly to you for services billed by us, you agree to promptly submit same to Orthopedic Associates until your patient account is paid in full. If you make a payment that results in a surplus on your account, you authorize Orthopedic Associates to apply the overpayment to any other account for which you are financially responsible, including your account, a member of your family's or dependent's account, or on any account for which you are a Financial Responsibility Party, and any remaining balance will be returned to the payor.

7. You will be mailed a billing statement that contains the total cost of your service(s) or procedure(s) received during your visit(s). You may generally expect this billing statement within twenty (20) days after your insurance company has responded to a submitted claim. You must notify us of any errors or objections to the billing statement within thirty (30) days or they will be deemed accurate, and the fees and expenses shall be deemed reasonable and necessary for the services incurred. If there is a problem with your account, it is your responsibility to contact the Patient Accounts Staff to address the problem or to discuss a workable solution.

8. Whether or not you have insurance or are self-pay, payment of any account balance is due at our office within thirty (30) days of receipt of your billing statement. If any balance on your account is over ninety (90) days past due, your account will be in default and auto referred to a collection agency

9. We accept payment by check, cash, money order, debit cards or credit cards (Visa, MasterCard or Discover).

a. Payment by Check. If payment is made by check and it is returned or declined for any reason, your account will be charged a surcharge of \$25.00 or up to the applicable state maximum legal limits, whichever is lower, in addition to any costs assessed or charged by any depository institution. When you pay by check you also authorize Orthopedic Associates, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limits (plus any applicable sales tax). PLEASE NOTE: The above language authorizes an electronic debit to your account for the amount of the check plus the state-allowed recovery fee. In accordance with the rules of the National Automated Clearing House Association, this authorization is to remain in effect until Orthopedic Associates has received written notice of termination in such time and in such manner to afford us a reasonable opportunity to act on it. This does not, however, mean that Orthopedic Associates cannot collect a returned check fee by other methods.

b. Payment by Credit Card/Credit Card on File. When you pay by Credit Card to be held on file, you agree to keep the credit card information current, and you authorize Orthopedic Associates to securely store your credit card information, and only charge it should you have an outstanding balance or any leftover balance from a processed claim in the future. The storage system used is fully compliant to the highest level of credit card storage security regulations. Once stored, only the last 5 digits of your credit card are viewable by Orthopedic Associates personnel. You understand that you are responsible for all charges for services that you receive from Orthopedic Associates, and if the patient responsibility portion of your charges (including charges applied to your deductible and/or coinsurance) is not paid in full within thirty (30) days following receipt of the financial responsibility statement, then Orthopedic Associates will bill your stored credit card for the outstanding balance due.

10. Managed Care (HMO, PPO, etc.). All managed care co-payment amounts are due at the time of service. If your insurance plan requires a referral authorization from a primary care physician, you are responsible for presenting this at your initial visit. If you request an office visit without a referral authorization, your insurance plan may deem this as “out of network” or “non-covered” treatment, and you will be responsible for a larger amount or all of the charges. You acknowledge that it is your responsibility to be aware of what services are covered and you agree to pay for any service deemed to be non-covered or not authorized by the plan.

11. Medicare. Orthopedic Associates is a participating provider with the Medicare program and accepts as payment the Medicare allowable, patient deductible and/or 20% co-insurance. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. You understand that you will be responsible for your annual deductible, the co-payment, and any non-covered services specified by Medicare. We may submit a claim to any supplemental plan as a courtesy to you, so long as you provide all necessary policy information.

12. Medicaid. If you are a Medicaid patient, you must present a valid eligibility card at the time of registration and prior to the time of service. Your eligibility status will be verified monthly. Without

verification of coverage, you will be responsible for the full/entire balance of your account. As a courtesy to you, your account will be billed to Medicaid when we receive all necessary information. You are responsible for non-covered portions and spend-down requirements associated with your individual coverage. If at any time you are not eligible for Medicaid coverage and wish to be seen, you will be treated as a self-pay patient and must make payment at the time of service.

13. Workers' Compensation Cases. Charges for services incurred as a result of a verified work related injury will be treated as workers' compensation, and we will bill the workers' compensation carrier as a courtesy. You must provide necessary information to bill the carrier. You are responsible for the completion of information with the employer and approval of the workers' compensation claim. In case your workers' compensation claim is denied, you will also provide us with your medical insurance information. If your claim is denied, we will bill your regular medical insurance carrier. When the claim is no longer pending and any portion of your claim is ultimately resolved against you by workers' compensation and your medical insurance, you will be required to pay all amounts due within thirty (30) days.

14. Third Party Liability Injuries. If you receive treatment as a result of a third party liability injury (for example: motor vehicle accidents, premises liability, or other general liability claims against third parties), the balance for services rendered is considered due in full at the time of the service. Because Orthopedic Associates does not protect charges incurred relating to or arising out of third party liability, we will not accept a delay in payment due to settlement disputes and/or litigation. We will not accept a letter of protection from an attorney as a guarantee of payment or assignment of third party insurance payments. Orthopedic Associates cannot act as administrator to resolve financial arrangements. We may agree to bill a third party insurance company of an at-fault party involved in an accident as a courtesy to you. To bill your claim directly, you must provide us all necessary information to confirm coverage for these payments with the auto/third-party carrier. We will also collect information about your personal medical insurance in case the auto/third-party carrier denies your claim. Regardless of whether we submit your claim to third-party insurance, as the patient, you are ultimately responsible for payment.

15. Ancillary Services. You may receive ancillary medical services while a patient of Orthopedic Associates such as: physical therapy, durable medical equipment, interpretation of tests, , imaging services (e.g., x-rays, MRIs) and pathology specimen examination. By signing below, you understand that some physicians may not provide services in your presence, but are actively involved in the course of diagnosis and treatment. You authorize payment directly for these services under the policy(s) or plan(s) issued to you by your insurance carrier. You may incur additional charges as a result of these ancillary services. You agree to pay all charges due with respect to such services after benefits paid on your behalf by any third-party are credited to your account.

16. Additional Charges. Patients may incur and are responsible for the payment of additional charges at the discretion of Orthopedic Associates including but not limited to: (i) charges for returned checks; (ii) charges for a missed appointment without 24 hours advance notice; (iii) charges for extensive phone consultations and/or after-hours phone calls requiring treatment, or prescriptions; (iv) charges for

copying and distribution of patient medical records; (v) charges for extensive forms preparation or completion; or (vi) any costs associated with collection of patient balances, all as allowed by law.

17. Non-payment on Account. Should collection proceedings or other legal action become necessary to collect an overdue or delinquent account, you understand that Orthopedic Associates has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. You are responsible for all costs of collection including, but not limited to: (i) late fees and charges and interest due as a result of such delinquency; (ii) all court costs and fees (but only to the extent allowed by law); and (iii) a collection fee to be charged under separate agreement with a third-party collections agency, either as a flat fee or computed as a percentage of the total balance due up to the maximum allowed by applicable law, and to be added to the outstanding balance due and owing at the time of the referral to the third party collection agency. You acknowledge that any such interest assessed on the account will be a late fee as a result of default or delinquency on your account, and is not deemed interest as part of a credit transaction. If your account is referred to a collection agency, attorney, court, or the past due status is reported to a credit reporting agency, it may have an adverse effect on your credit history; and related portions of your account, including the fact that you received treatment at our offices, may become a matter of public record. Failure to comply with any of these policies may also result in a Credit Withdrawal of Care.

18. Minor Patients. The parent/guardian of a minor is responsible for payment of the minor's account balance. A minor who is not accompanied by a parent/guardian will be denied any non-emergency treatment unless charges for the treatment have been pre-authorized. Responsibility for payment of treatment of minor children, whose parents are divorced, rests with both parents. Any court-ordered responsibility judgment must be determined between the individuals involved, without the inclusion of Orthopedic Associates.

19. Authorization to Contact. You authorize Orthopedic Associates personnel to communicate by mail, answering machine messages, and/or e-mail according to the information provided in your patient registration information. Orthopedic Associates, or any agent or servicer of your patient account, may use any information you have provided, including contact information, e-mail addresses, cell phone numbers, and landline numbers, to contact you for purposes related to your account, including debt collection. You authorize Orthopedic Associates to use this information in any manner consistent with the information you have provided, including mail, telephone calls, e-mails, or text messages. You expressly consent to any such contact being made by the most efficient technology available, including automatic dialing/e-mailing or similar equipment, or pre-recorded or other messages, even if you are charged for the contact.

20. Financial Responsibility Party. If this or a separate Orthopedic Associates Financial Responsibility Statement is signed by another person, on your account, then that co-signature remains in effect until cancelled in writing. Cancellation in writing shall become effective the date after receipt, and shall apply only to those services and charges thereafter incurred. By signing as Financial Responsibility Party, you hereby guarantee the full and prompt payment to Orthopedic Associates of all indebtedness of Patient to Orthopedic Associates, whether now existing or hereafter created (the "Indebtedness"); and you

further agree to pay all expenses, legal or otherwise, incurred by Orthopedic Associates in collecting the Indebtedness, in enforcing this guaranty, or in protecting its rights under this guaranty or under any other document evidencing or securing any of the Indebtedness. This guaranty shall be a continuing, absolute and unconditional guaranty, and shall remain in force and effect until any and all said Indebtedness shall be fully paid. There shall be no obligation on the part of Orthopedic Associates at any time to first exhaust its remedies against Patient, any other party, or any other rights before enforcing the obligations of Financial Responsibility Party.

**Acknowledgement**

By signing below, each of the undersigned acknowledges that: (i) I have been provided a copy of the Orthopedic Associates of Port Huron, P.C. PATIENT FINANCIAL RESPONSIBILITY STATEMENT; (ii) I have read, understand, and agree to their provisions and agree to the specified terms; (iii) I agree to pay all charges due (or to become due) to Orthopedic Associates for the below Patient’s care and treatment, including copayments and deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable; (iv) benefits, if any, paid by a third-party will be credited on the Patient account; (v) regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any services rendered; (vi) if I failed to make any of the payment for which I am responsible in a timely manner, I will be responsible for all costs of collecting the money owed, including court costs, collection agency fees, and attorneys’ fees (to the extent allowed by law); and (vii) failure to pay when due may subject me to late payment charges and can adversely affect my credit report.

I further agree that a photocopy of this Patient Responsibility Financial Statement shall be as valid as the original.

ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FACSIMILE OR ELECTRONIC (“.PDF”) SIGNATURE, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

I Agree                       I disagree

\_\_\_\_\_  
Patient/Responsible Party/Guardian Signature

\_\_\_\_\_  
Date

**Waiver of Patient Authorizations**

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

\_\_\_\_\_  
Patient/Responsible Party/Guardian Signature

\_\_\_\_\_  
Date