Independence Orthopedics & Sports Medicine
Office Financial Policy

It is the policy of this office to help keep your healthcare costs as low as possible. Please help us in the following ways:

1. Pease bring your current health insurance card at every visit
2. Please notify us at time of check-in of any changes in insurance, address, phone number, etc.
3. Please pay your co-insurance or deductible before your appointment
4. Please have the proper referral and/or authorization from your insurance company.
5. You are responsible for verifying the participation status of the physician you are seeing.
6. There will be a $25 fee for returned checks
7. Patients arriving 15 minutes after their scheduled appointment time will be rescheduled.
8. We require 24 hour notice if you cannot keep your appointment. Failure to do so will result in a $25 charge.
9. If your insurance company does not respond within 60 days, you will be required to pay the balance at that time.
10. If you require a copy of your medical record, please give us 3 days notice. Please be aware that there is a per page charge to cover the cost.
11. There will be a $25 charge for Disability, and Insurance forms that will be due up front.
12. All self-pay patients will be responsible for service rendered at the time of service.

You should receive a bill for any patient responsibility within 30 days, and/or explanation of benefits from your insurance provider. If you do not, please contact the billing office at (513) 523-2663.

Insurance Release:
I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize my physician to release to the Social Security Administration or to its intermediaries of carriers any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to my physician on claims for which they have accepted assignment, and I authorize the physician to submit a claim to Medicare for payment on my behalf. I request that payment under the medical insurance program be made to my physician on any bills for services furnished me by my physician for which they have accepted assignment. I further release my physician to release medical information concerning my treatments to Blue Shield or other insurance carriers and I authorize payment of medical benefits from those carriers to be made directly to my physician on claims for which they have accepted the assignment. I also understand that I am responsible for payment for services not covered by the Medicare program.

I also authorize my physician's office to provide my medical information to other organizations or entities for the determination and payment of benefits. I authorize my physician's office to permit my insurance companies or third party payors to review/audit my medical chart if they so request. I assign benefits otherwise payable to me to my physician. We will file all insurance claims for you.

This is to certify that I have been informed prior to receiving treatment today that my health plan may not be liable for services rendered if any of the following conditions apply:

1. I may have a pre-existing condition or other diagnosis that my not be covered by my plan
2. My insurance carrier may not have established medical necessity for this procedure/treatment
3. My provider is not participating in my health plan
4. I have not met my deductible under my health plan contract
5. The services I receive may not be covered under my health plan
6. I may not have obtained the proper authorization and/or referrals for my treatment

Therefore, knowing this, I request that services be performed and I agree to be responsible for any charges incurred. If my account becomes delinquent or is turned over to a collection agency or attorney for collections, the undersigned shall pay all collection agency fees, court costs, and attorney fees.

I have read the above, agree to my financial responsibility as outlined above, and understand that I am ultimately responsible for the charges incurred by me.

_____ _____

Patient Date Physician Staff Member Date