INSTITUTE for HAND & ARM SURGERY

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PATIENT FINANCIAL POLICY

Our practice goal is to be your partner in providing care. Letting you know in advance our Financial Policy provides for a good flow of communication and enables us to achieve that goal. **Please read this carefully**. If you have any questions, do not hesitate to ask a member of our staff.

1. We request that you present your current insurance card upon arrival to your initial visit and notify us of any changes on subsequent visits.
2. **According to your insurance plan, you are responsible for any and all co-payments, deductibles, co-insurances and medical services not covered by your plan**.
3. **It is your responsibility to understand your benefit plan** and to know if a written referral or pre-authorization is required. Our staff is available to help.
4. **If we do not participate in your insurance plan or you do not have insurance, payment in full is expected. You agree that payment of insurance benefits for all services rendered to you are to be made on your behalf to Institute for Hand & Arm Surgery. *Outstanding balances must be paid prior to a scheduled visit.***
5. **Certain insurance carriers will send our payment directly to your home address. It is expected that you will forward that payment to our office, along with the Explanation of Benefits.**
6. Co-pays are due at the time of service. A $10 processing fee may be charged in addition to your co-pay, if the co-pay is not paid at the time of service.
7. You have an option of having a credit or debit card number stored securely with our office. **IF YOU DECLINE THE CREDIT-CARD-ON-FILE OPTION, OR THE CARD IS INVALID OR EXPIRED AT THE TIME OF CHARGE, OUR OFFICE WILL ASSESS A FEE OF ONE PERCENT (1%) FOR EACH MONTH ON ANY UNPAID BALANCE NOT COVERED BY INSURANCE WHICH IS NOT PAID WITHIN THIRTY (30) DAYS OF OUR STATEMENT.**
8. We will invoice you after receipt of your insurance plan's Explanation of Benefits if there is a balance due. Your payment is due **10 business days from receipt of your statement**. Any balance past due for 45 days or longer will be turned over to our collection agency unless other payment arrangements have been made with us.
9. **A fee of $40 will be charged if you miss a confirmed appointment or fail to cancel an appointment at least 24 hours in advance.** A new appointment will not be made, unless we have your credit card on file.
10. **Patients who accumulate three (3) no shows/same day cancellations within a 12-month period will automatically be terminated from our practice.** Exceptions may be made depending on the specific circumstances.
11. Our secure patient portal is available online. This service allows access to medical records, direct communication with your doctor, and on-line request for appointments.
12. A **$45 fee** will be charged for any checks returned. Additional fees from the bank may also be charged.
13. If you have forms to be completed, there is a charge. Payment is due when the forms are dropped off. We require a minimum one-week turnaround time for those forms.

I, _____, understand and agree to the Patient Financial Policy.

X_____ Date_____
Signature of Patient or Responsible Party

I authorize Institute for Hand & Arm Surgery to charge the portion of my bill that is my financial responsibility to the following credit or debit card. I agree to pay such amount according to my credit issuer agreement (merchant agreement if credit voucher). We reserve the right to charge a 3% fee for credit card payments.

Date: _____ □AMEX □VISA □MasterCard □Debit Amount: $_____

Credit/Debit Card # _____ CVN # _____ Exp. Date _____

Cardholder Name _____ Signature _____

Billing Address _____