BLOUNT ORTHOPAEDIC ASSOCIATES

Patient Accounts Department
Orthopaedic Hospital of Wisconsin Medical Office Building
525 West River Woods Parkway, Suite 100 • Glendale, WI 53212 • (414) 332-6262

BLOUNT ORTHOPAEDIC ASSOCIATES FINANCIAL POLICY

As a patient of Blount Orthopaedic Associates, you are required to sign a financial responsibility form prior to receiving services within our office. This form explains how we process billing of the services you will receive and your responsibility for payment of those services. We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you. Blount Orthopaedic Associates has a Patient Accounts Department that manages all aspects of billing for the services you receive through our group and are available to assist you in those matters. Your CLEAR understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions at all.

COMPLETION OF REGISTRATION FORMS: All patients are required to fill out the Patient Registration forms prior to seeing the physician in the office. These forms are required to be updated AT LEAST ANNUALLY and sooner if changes occur. This allows us to keep your information ACCURATE and CURRENT. Please inform us immediately with any changes - address, insurance coverage, new injury information, etc. this will allow us to assist you in processing your claims appropriately.

INSURANCE CARD(S): Patients are required to present their HEALTH INSURANCE card(s) for copying into your record. This provides us with the information to submit your claim (claim address, policy and group numbers, precertification numbers, etc.). Without your card, you MAY be required to reschedule your appointment until the information can be provided and verified. We require the private health insurance cards EVEN IN CASES of worker's compensation and third party liability. Based upon the information you provided, we will file a claim for the services rendered to the carrier.

COPAYMENTS: Your insurance REQUIRES that we collect your designated co-pay AT THE TIME OF SERVICE. As such, your appointment MAY be rescheduled if you are unable to make the payment. Please be prepared to pay the co-pay at each visit. Our group is considered under the SPECIALIST category for co-payments - NOT the PCP (primary care physician). Chronic non-payment can constitute severance from the Practice.

SELF PAY PATIENTS: All Self-Pay patients and patients who present without proof of insurance are required to pay $500 in cash, money order or credit card at the time of service and set up payment arrangements with our Patient Accounts Department.

FORMS OF PAYMENT: We accept Cash, Checks, Visa, Mastercard and Discover.

REFERRALS: If your plan requires a referral from your primary care physician it is YOUR responsibility to obtain prior to your appointment and to have it with you at the time of the appointment or prior to. If you do not have your referral, you MAY have to reschedule your appointment and may be subject to the penalties of your insurance (higher copay, deductible, non coverage) for being seen without a valid referral.

WORKERS COMPENSATION: It is the responsibility of the patient to notify us IMMEDIATELY of an injury whereby there is a claim of workers compensation. Claiming a work related injury does NOT absolve the patient from being financially responsible for the medical services that are provided. The patient must provide the date of injury, claim#, insurance company name, address, phone, adjuster name and phone, so that our Patient Accounts department can verify the status of the claim and process the billing appropriately. In our state, if workers compensation is denied, and you have private health insurance, they may be billed. If they do not pay, the patient is responsible for payment. It is imperative that you communicate any changes in your claim to the Patient Accounts Department (ie. Denial of claim, filing of a hearing, being sent for an IME, etc.) so that we can work with you and your account in a timely manner.

ACCIDENT/LIABILITY CASES: It is the responsibility of the patient to notify us IMMEDIATELY of an injury whereby there is a claim of liability through another party (auto, slip and fall, etc.) Patients are financially responsible for all medical services provided - filing of a claim does NOT absolve the patient from being financially responsible. We do NOT bill attorneys or third party payers* for liability (*exception is required by Medicare) cases. We do NOT accept letters of protection.

CHILD CUSTODY CASES AND SECOND PARTY INSURANCE: We will bill the insurance carrier for both parents. However, the parent that signs for services will be responsible for ALL outstanding charges and balances unless you have produced a court order stating otherwise, with name and address of the responsible party.

NON PARTICIPATING INSURANCE PLANS or OUT OF NETWORK: As a service to our patients, we will bill a non participating claim. All outstanding balances are the responsibility of the patient. I understand if I elect to be treated, I am directly responsible for my payments and may not be reimbursed by insurance.

OUTSTANDING BALANCES: If you have any outstanding self-pay or insurance designated outstanding balances for copays, deductibles, non covered services and the like, and you have been billed more than once without payment, you MAY be required to reschedule your appointment. Payments on outstanding claims are due monthly. Do NOT depend or wait on your insurance carrier to make payment. Services were rendered to YOU, not the carrier and you are financially responsible for payment on those services. On occasion, your insurance may determine the care you have received is NOT a covered benefit. These costs may revert to you directly on your insurance carrier's Explanation of Benefits. YOU are responsible to pay these charges if that happens. Please read your insurance handbook and be aware of what your insurance offers for benefits. When in doubt, contact your insurance company directly for clarification. Do not hesitate to contact our Patient Accounts department for assistance. Chronic non-payment of bills you are directly responsible for can constitute severance from the Practice.

RETURNED CHECK FEES: Any returned check from the bank for non-payment or insufficient funds shall result in the patient's account being assessed an additional $50.00 per check returned.

FRACTURE CARE: Injections, joint aspirations and fracture care are all procedures listed as "SURGICAL" for billing purposes by insurance companies. Though these services may be provided in the office or emergency room, they are generally listed on your explanation of benefits or bill as "SURGERY''. Some insurance companies require that fracture care billing be done on a "global" basis. This means that for a pre-determined amount of time all professional services related to the "surgery'' or fracture care are included within the initial fee. X-rays and casting/splinting, along with related supplies are NOT included within the global fee and are billed separately.

DISABILITY/INCOME REPLACEMENT INSURANCE FORMS: There is a charge for completing any form that is not directly related to reimbursement of medical services. For compliance purposes, the patient information portion of the form MUST be completed and signed PRIOR to acceptance along with completion of our form and fee payment. Form services must be paid for in FULL prior to completion by our office. This fee is typically waived for patients while they are under a "global period" .

I have read the Financial Policies of Blount Orthopaedic Associates and agree to comply with the Financial Policies.

_____
Patient (or Representative Guardian/Parent) Name PRINTED

_____ _____
Patient (or Representative Guardian/Parent) Name SIGNATURE DATE

RELEASE OF MEDICAL RECORDS FOR BILLING PURPOSES:

In order for my claim for services to be considered for payment, I understand that my carrier may require information about the medical care and treatment received . I authorize Blount Orthopaedic Associates or its related entities to release any information needed to determine the payments related to the medical treatment I receive.

_____ _____
Patient (or Representative Guardian/Parent) Name SIGNATURE DATE

ASSIGNMENT OF BENEFITS/PAYMENTS:

I request that payment of my medical claims be made to Blount Orthopaedic Associates on my behalf for any services furnished to me by or in Blount Orthopaedic Associates and associated staff. I assign the benefits payable for physician services to Blount Orthopaedic Associates or the physician furnishing the services.

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