



Patient Financial Policy

At Missoula Bone & Joint we are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Our fees for services are based on the level of professional skill required, the severity and complexity of the injury or illness, as well as the time spent treating you. The **patient or responsible party** is responsible for seeing that the entire bill is paid in full. Your clear understanding of our Financial Policy is important to our professional relationship.

Self-Pay / Uninsured: We ask that all self-pay or uninsured patients process payments through the HealthMe Marketplace prior to their visit. This platform, which is on our website, offers bundled care packages at reduced rates, allowing patients to select services that best meet their personal healthcare needs. HealthMe pricing is lower than the standard time-of-service rates. For patients choosing not to go through their insurance, a deposit of at least \$200 is required on the day of your appointment before being seen by the provider. Any fees remaining will be collected following your appointment at a discounted rate and must be paid in full. You have the right to receive a "Good Faith Estimate" for the total expected cost of any non-emergency care provided. Please inquire if you have not received a Good Faith Estimate.

Insurance: Billing of insurance is a courtesy we provide our patients and is not required by law. Our services are provided to the patient, not the insurance company. If your insurance does not respond within 30 days, the balance becomes your responsibility. Please notify us of any insurance changes.

Copays, Deductibles & Co-Insurance: Your insurance requires that copays be paid at time of service. After your visit, we will bill your insurance as a courtesy. Any deductible or co-insurance amounts are your responsibility and must be paid upon receiving your statement. For certain services, prepayment of deductibles or co-insurance may be required. Please contact your insurance with questions about amounts owed.

Non-Covered Services: If your insurance plan determines that a service is not covered for any reason you will be responsible for payment of the charges. **Durable Medical Equipment (DME):** Some DME items may not be covered by your insurance plan and you will be asked to pay in full at the time of service. All items are new when given and cannot be returned.

Non-Participating Insurance Plans or "Out of Network": Patients are responsible for verifying if Missoula Bone & Joint is in-network with their insurance. Any outstanding balances are the patient's responsibility. Insurance terms like "usual and customary" or "out of network" refer to amounts determined by your insurance company and may not reflect our actual charges. You may be asked to sign a consent form under the No Surprises Act before receiving services.

Referrals: If your insurance plan requires a referral from your primary care physician or "Passport Provider" it is your responsibility to obtain this prior to your appointment and have it with you at the time of the appointment. If you do not have your referral you may be required to reschedule.

Workers Compensation/Accident Cases: To bill your work comp or liability insurance, you must provide complete billing information before your visit. Without it, full payment is due at the time of service. We do not bill out-of-state work comp if contacted after the visit. We also do not bill private insurance for work comp or accident-related care unless the claim is denied or benefits exhausted. Patients are responsible for any unpaid balances. We do not accept letters of protection or bill attorneys.

VA Patient Notice: A valid VA authorization is required for each date of service. The VA will pay for services that fall within the approved dates and types of care listed in the authorization. You are responsible for any dates or services not listed. Please confirm we have authorization on file.

Minors of Divorced Parents and Child Custody Cases: Both parents are financially responsible for care rendered to minor children. We do not get involved in divorce situations and the parent that signs for the child will be financially responsible and any statements will be mailed directly to that parent.

Post-Operative Surgery Charges: Following most surgical procedures, related office visits are included and will not be charged during the 10 or 90 day post-operative period. Services such as x-rays, casting and materials, Durable Medical Equipment, and injections will be charged separately during this time.

Completing Patient Forms: Please allow 5-7 business days for completion of paperwork of forms relating to disability, FMLA, etc.

Responsible parties will be responsible for any expenses not covered by insurance and any costs incurred in collecting the amounts owed, including attorney fees, court costs and/or the collection agency fee. Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being assessed a \$25 fee per check returned. *Payment for services may be paid by cash, personal check, or credit card.* **By signing below, I acknowledge that I have read and agree to this Financial Policy.**

Responsible Party Signature: _____ **Date:** _____

Patient Name (if different from Responsible Party): _____

ASSIGNMENT, RELEASE OF INFORMATION, AND CONSENT TO TREAT

NOTE: **Insurance Pre-Authorization:** It is the patient's responsibility to notify this office if your insurance carrier requires pre-authorization for any services. **Assignment and Release of Information:** I hereby authorize Missoula Bone & Joint to release any information acquired in the course of my examination and treatment to the insurance company. I also authorize payment directly to the physician. **Consent to Treat:** I also hereby request and consent to treatment and services reasonable and proper by applicable standards provided by a provider of Missoula Bone & Joint and any employee acting under my provider's orders.

By signing below, I understand as stated above that I authorize payment directly to MBJ, authorize to release necessary information, and give consent to treat.

Patient/Guardian Signature: _____ **Date:** _____