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: Payment in full is required for all self-pay/uninsured patients. For new patients, a deposit of $200 is required on the day of your appointment before being seen by the provider. Any fees remaining will be collected following your appointment. You have the right to receive a "Good Faith Estimate" for the total expected cost of any non-emergency care provided. Please inquire with our office 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 professional services are rendered to a person, not an insurance company. The insurance company is responsible to the patient and the patient is responsible to us. Therefore, if your insurance does not respond within 30 days the bill will become your responsibility. Please notify us if your insurance carrier or policy has changed.

Copayments: Your insurance contract REQUIRES that we collect your designated co-pay at the time of service. Please be prepared to pay your co-pay at each visit.

Deductibles and Co-Insurance: Following your appointment, as a courtesy we will bill your insurance company, and any deductible and/or co-insurance portion will be your responsibility and are to be paid upon first receipt of your patient statement. If you have questions regarding any amount due after insurance has processed your claim please contact them directly. You may be required to pay all or a portion of your deductible and/or co-insurance prior to certain services being rendered.

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": It is the responsibility of the patient to verify whether Missoula Bone & Joint contracts with your insurance plan. Any outstanding balances are the responsibility of the patient. Insurance companies sometimes use the phrase "usual and customary" or "out of network" when discussing our fees. Insurance companies set their own "usual and customary" rates based on a wide geographic area and the fees we charge may differ. You may be asked to sign a consent form prior to services being rendered in regards to the No Surprises Act.

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: In order for us to file a claim with your work comp or other liability carrier you must provide complete billing information. Without this information we are unable to bill your insurance carrier and we will ask for payment in full at the time of service. Patients shall be financially responsible for medical services related to work comp/accident if insurance fails to pay in full. We do not accept letters of protection or bill attorneys for medical services.

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. *Payment for services may be paid by cash, check, Visa, MasterCard, Discover, or American Express.* **Responsible parties** will be responsible for any expenses incurred in collecting the amounts owed, including attorney's 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. ***By typing your name below, you are acknowledging that you have read and agree to this Financial Policy.***

Responsible Party Signature: _____ Date: _____

Patient Name (if different from Responsible Party): _____

ASSIGNMENT AND RELEASE OF INFORMATION

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. **By typing your name below, I understand that I am responsible for any amount not covered by insurance and if my account is turned over to a collection agency I will be responsible for the agency's fee.**

Patient/Guardian Signature_____ Date: _____

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.

Patient/Guardian Signature_____ Date: _____