

FINANCIAL POLICY

Carolina Orthopedics & Sports Medicine, Inc. wants to assist you in the financial management of our relationship. Please be advised that this is not an all inclusive list. Benefit verification will be provided as a courtesy and is not a guarantee of payment. Be assured that we will be ethical and fair concerning any billing or collection concern you may have. If you have any questions, please speak with our Patient Accounts Office by dialing our main number (252-634-2676) and selecting option 3.

Participating Provider Plans

- A list of our participating provider plans is in the lobby for your convenience.
- Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
- Our billing department will file your insurance for services rendered.
- The patient is responsible for presenting all current available insurance cards at the time of service.
- The patient is responsible for co-pays, deductibles, and co-insurance at the time of service. (If you have Medicare and a supplemental we will file Medicare and supplemental ; then transfer balance to you after your supplemental has paid on claim. If you do NOT have a supplemental insurance, you will be responsible for the 20% of Medicare allowable for each service plus any deductible.)
- The patient is responsible for knowing their policy coverage, deductibles, coinsurance, etc.

Non-Participating Plans

- The patient is responsible for all "out of network" patient responsibility at time of service unless other payment arrangements have been made. This would include any co-insurance, deductible, and the difference between carriers allowable and our standard fee.
- Our billing department will file patient insurance as a courtesy.
- Acceptance of co-pay DOES NOT constitute participation with your insurance carrier NOR will it be deemed as payment in full for services rendered. Your claim will be processed by your carrier and you will be billed for the balance on your account.

Self Pay

- Patients with no insurance coverage or proof of coverage, will be considered self-pay.
- Self-Pay patients will sign this form indicating that they have NO health insurance.
- Payment is due at time service is rendered or arrangements must be made prior to treatment.

Collections

- Collection efforts begin if a balance has not been paid within 60 days.
- All unpaid balances will be sent to an outside collection agency after all practice efforts have been exhausted. Attorney fees and collection costs will be the patient's responsibility in the event of default of payment, which could also result in a negative credit rating.

Workers Compensation

- We MUST have authorization from YOUR employer to file Workman's Comp. Your Social Security number is required to file a Workman's Compensation claim. If for any reason your employer or employer's insurance carriers rules that your claim is non work related; you will be responsible for charges incurred for services rendered.

Return Check Fee

- A fee of \$25.00 (or amount allowed by law) will be charged to patient account for Return Checks.

Outside Laboratory Test

- From time to time, our physicians may order laboratory tests that cannot be completed in our facilities. In this situation, blood is drawn and sent to an outside lab for testing. When this occurs, our patients may receive a separate bill from the outside lab for tests performed.

PATIENT AUTHORIZATION

I, hereby consent to the rendering of medical care, which may include routine diagnostic procedures, laboratory testing, medical and/or surgical procedures and physical and/or occupational therapy performed by authorized physicians and/or staff members of Carolina Orthopedics & Sports Medicine, Inc.

I understand terms are for services rendered. I will be responsible for all charges incurred by me and/or my dependents. Should collection proceedings become necessary, I agree to pay all costs of collection, including a reasonable attorney's fee. I hereby assign to and authorize payment directly to Carolina Orthopedics & Sports Medicine, Inc. All benefits payable under the terms of any insurance policy listed above. If insurance is filed by Carolina Orthopedics & Sports Medicine, Inc., I realize the insurance benefit may not pay the entire bill and agree to pay the difference or the entire bill, if necessary. I authorize the release of any medical information necessary to process my insurance claims or to continue my medical care. I acknowledge that I have been provided access to the Notice of Privacy Practices of Carolina Orthopedics & Sports Medicine, Inc. Carolina Orthopedics & Sports Medicine, Inc's Notice of Privacy Practices explains to me use and disclosure of my protected health information (PHI). Carolina Orthopedics & Sports Medicine, Inc. may use any contact information (home telephone, cellular telephone, e-mail and text message) supplied by you to notify of appointments, laboratory results, referrals or billing matters.

Signature Patient/Responsible Party _____

Date: _____

MEDICARE PATIENTS ONLY:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care financing Administration or its intermediaries or Carriers any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I also understand that I am responsible for the deductible, coinsurance, and any non-covered services as determined by Medicare.

Signature Patient/Responsible Party _____

Date: _____

NOTICE OF PRIVACY PRACTICES

List any persons to whom you WILL allow access of your medical records and/or information concerning your healthcare:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

You have the right to request restricted use and disclosure to certain individuals. Carolina Orthopedics & Sports Medicine, Inc. is allowed, by law to deny any request that impedes treatment, payment or healthcare operations. Please list any restrictions below:

Individual(s) _____ Reasons: _____

Expiration: This consent is valid until such time I provide Carolina Orthopedics & Sports Medicine, Inc. written revocation.

May we call you at work?	Yes _____	No _____	N/A _____
Leave a message on your answering machine?	Yes _____	No _____	N/A _____
Send an appointment reminder?	Yes _____	No _____	N/A _____
Call on a cell phone?	Yes _____	No _____	N/A _____

Any other Restrictions?

Signature Patient/Responsible Party _____

Date: _____

Restrictions reported to Safety Officer

Date _____

Signature of Employee _____