

Cape Fear Orthopaedic Clinic, P.A. Financial Policy (Revised 9/20/2007)

Patient Name: _____ Chart # _____

The intent of this document is to inform you of Cape Fear Orthopaedic Clinic’s financial policies. Because we are committed to providing you with the best possible care and service, it is essential that you have a complete understanding of your financial obligations.

1. CFOC files insurance claims as a courtesy for **ALL** of our patients. However, we are only obligated to accept insurance *payment* from those companies with which we have a contractual agreement. If we do not participate with your insurance plan, you are responsible for paying your bill in full at the time of service.
2. COPAYMENTS and prior balances, such as deductibles and coinsurance, must be paid at the time of service. You should be prepared to pay prior to being seen. Our office does reserve the right to reschedule your appointment should you be unprepared to make payment when it is due.
3. We accept CASH, CHECKS, MONEY ORDERS, TRAVELER’S CHECKS, DEBIT CARDS, MASTERCARD, VISA and DISCOVER CARD as payment for services rendered.
4. Prior balances must be paid in 30 days unless a signed payment plan has been executed. Past due balances may be subject to additional collection and legal fees. We reserve the right to turn any account over to a collection agency if the account is in default of the payment obligation or compliance with this policy. Furthermore, a patient may be dismissed from care should his/her account be turned over for collection and/or legal action.
5. We do offer payment plans for those patients who are unable to make full payment when due. Patients should request payment plan options **PRIOR** to being seen. We do offer discounts to our uninsured patients or patients enduring financial hardship. Please see our financial counselor prior to your appointment to inquire about assistance.
6. A \$25.00 returned check fee will be assessed to your account for each returned check. A patient will be considered “CASH ONLY” if two (2) checks are returned for non-payment.
7. There may be an additional charge of \$20.00 applied to your account if you fail to cancel an appointment without at least 24 hours advance notice. Three missed appointments constitute grounds for dismissal from the practice. Whether or not you will be discharged under these circumstances is left to the discretion of your physician. Please help us serve you better by keeping scheduled appointments.
8. **CFOC does not accept third party payment for services related to motor vehicle accidents or other liability.** All charges for medical treatment provided by this clinic are the responsibility of the patient and are due when the service is rendered.
9. The parent who accompanies a minor child to his/her first appointment will be considered responsible for payment, regardless of the name of the subscriber (parent) listed on the child’s insurance card. It is our policy not to get involved in divorce or separation issues. CFOC considers any patient age 18 or older financially responsible even if he/she is still covered under a parent’s insurance policy.
10. Minor children ages 15 and under will not be treated without a parent or legal guardian present. Children ages 16 and 17 may be treated without a parent present only if we have a “Consent to Treatment of a Minor” authorization on file. Any parent who anticipates that his/her child may not have a parent or legal guardian present, should request the proper authorization form at the front desk.

I hereby assign to Cape Fear Orthopaedic Clinic, PA any insurance or other third-party benefits available for health care services provided to me and authorize the release of my Protected Health Information (PHI), if necessary, to ensure payment of my insurance claims. I understand that Cape Fear Orthopaedic Clinic, PA has the right to refuse to accept assignment of benefits in certain circumstances. If these benefits are not assigned to Cape Fear Orthopaedic Clinic, I agree to forward insurance or third-party payments that I receive for such services, immediately upon receipt.

Signature of patient/legal guardian Date

As part of our effort to comply with HIPAA Privacy Regulations, we ask that you please provide the name of family members or other persons, if any, to whom we may release information regarding your general medical condition or financial account.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Receipt of Notice of Privacy Practices Written Acknowledgement

I, _____, have received a copy of Cape Fear Orthopaedic Clinic’s Notice of Privacy Practices.

Patient/Legal Guardian Signature Date