Account #	Patient:

Financial Policy

This is an agreement between Orthopaedic Associates of West Florida, P.A., a Florida Professional Corporation, as creditor, and the Patient/Debtor named on this form.

In this agreement, the words “you”, “your”, and “yours” means the Patient/Debtor. The word “account” means the account that has been established in your name to which charges are made and payments credited. The words “OAWF”, “us”, “our”, and “we” refer to Orthopaedic Associates of West Florida, P.A.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will separately show the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payments: Unless other arrangements are approved by OAWF in writing, the balance on your statement is due and payable when the statement is issued, and considered past due if not paid within 30 days.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Required payments: Any co-payment required by an insurance company must be paid at the time of service.

Payment options: You may choose to pay by cash, credit card, or check on the day services are provided.

Self Pay: Patient is required to pay at the time of service unless other arrangements have been made and agreed to by OAWF in writing prior to the appointment.

Insurance: Insurance is a contract between you and your insurance carrier. We are NOT a party to this contract in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance carrier that makes the final determination of your eligibility and determines payment. You agree to pay the portion of the charges not covered by your insurance carrier. If your insurance carrier requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance carrier, thus increasing the portion you would be responsible for.

As a courtesy, we will be happy to file your secondary insurance. However, it is our policy that should your insurance carrier not pay the claim within 45 days, the balance becomes your responsibility, and is payable at that time. If your insurance carrier makes payment after you have paid, you will be promptly refunded.

Personal Injury: If you are being treated due to a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. Payment of the bill remains the patient’s responsibility unless other arrangements have been agreed to by OAWF in writing prior to the appointment.

Account #	Patient:

Financial Policy cont'

Workers Compensation: We require written approval/authorization by your employer and/or workers compensation carrier prior to your initial visit. If your claim is denied or un-authorized services are performed, you will be responsible for payment in full.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for the minor patient will be responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt including the possibility of referring the account to a collection agency.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have he option to report your account status to any credit reporting agency such as the credit bureau.

Returned Checks: There is a $25.00 fee for any check returned by the back. The $25.00 fee will be added to your account upon notice from the bank.

Records/Radiology Copies: For copies of either your medical records or radiology films, there may be a charge for copies provided. This may not be covered by your insurance, and will be your responsibility.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collections agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Co-Signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective date: Once you have signed this agreement, you agree to all the terms and conditions contained herein, and the agreement will be in full force and effect.

Patient's Name: ____

Responsible Party
(If not patient) ____

Signature ____ Date ___________________________

Co-Signature (if required) ____ Date ___________________________

Witness ____ Date ___________________________

Witness Signature ____ Date ___________________________