

**Southwest Orthopedics, S.C. maintains the following policies:**

1. Co pays, past due balances and payments for services rendered are expected at the time services unless other arrangements have been made in advance. Once services have been rendered, the patient assumes the financial obligation of any insurance non-payment. Patient service discrepancies must be addressed to the practice within 24 hours of the date of service, no exceptions. We accept cash, personal checks, Visa, MC, AMEX and Discover.
2. As a courtesy, we will submit patient insurance claims to the primary insurance carrier. If the patient's insurance does not process claims within 60 days from date of service, we reserve the right to bill the patient directly for payment.
3. Patients are responsible for deductibles, co pays, non-covered services, coinsurance, and items considered not medically necessary by the insurance carrier.
4. Your account will be reviewed on the 90<sup>th</sup> day from the date service and if no payment is received in our office, we will forward the account to our contracted collections agency. Payment plans can be arranged but must be requested by the patient by calling (708) 581-2482.
5. Failure to cancel an appointment 24 hours in advance will result in a \$25.00 fee charged to the patients account.

**INITIAL AFTER READING POLICIES:** \_\_\_\_\_

**WORKERS COMPENSATION**

Workers Compensation patients should be covered by their employer's insurance when the injury was reported at work and verified by the employer. Patients are responsible for providing insurance carrier name, address, phone number, and claim number for us to process the workers compensation claim. **INITIAL AFTER READING POLICY:** \_\_\_\_\_

**PERSONAL INJURY (MOTOR VEHICLE ACCIDENTS OR OTHER LEGAL CASES)**

During the litigation period, patients are required to make a minimum monthly payment of \$100.00 until their case is resolved. If the patient can present valid claim information from a responsible party, we will bill the responsible for payment on services rendered. Any non-payment will be the responsibility of the patient. Attorney requests for financial liens or deferring payment pending resolution of cases are not recognized in this office. **INITIAL AFTER READING POLICY:** \_\_\_\_\_

**FORMS COMPLETION**

There will be a **\$10.00 fee** for completion of any forms. Allow 5-7 business days for completion. **INITIAL AFTER READING POLICY:** \_\_\_\_\_

**ASSIGNMENT OF BENEFITS**

I hereby assume full responsibility for and agree to pay all costs, charges, and expenses incurred by the patient, to Southwest Orthopedics, S.C. I understand and agree that this understanding constitutes a direct primary and personal undertaking by me and is not conditioned or contingent upon payment of any such costs, charges or expenses by any third party. And assignment of benefits of any insurance policy or medical reimbursement plan shall not be deemed waiver of the Provider's right to acquire payment directly from the undersigned. The Provider expressly reserves the right to require such payment. In the event that this obligation remains unpaid and requires referral for collection, the undersigned agrees to pay all costs of collection, including, but not limited to reasonable attorney's fees. If the undersigned is more than one person every obligation hereunder shall be joint and several.

I have read and understand the office policies and acknowledge that I will be fully responsible for payment of services rendered. I authorize the release of any medical or other information necessary to process my claims. I authorize payment of medical benefits directly to Southwest Orthopedics, S.C.

\_\_\_\_\_  
Patient or Responsible Party Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient, if Other than Yourself

\_\_\_\_\_  
Relationship to Patient

**AKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE**

I have received and have been presented with the opportunity to review the Southwest Orthopedics Privacy Notice during this visit/prior visit.

\_\_\_ Declined to sign      \_\_\_ patient initials (if patient/representative did not accept)

\_\_\_\_\_  
Patient/Spouse/Nearest Relative/Legal Guardian

\_\_\_\_\_  
Date