



Financial Policy

Thank you for choosing Flathead Orthopedics as your health care provider. We are committed to providing the best treatment possible at a reasonable and fair price. Your clear understanding of our Financial Policy is important to our professional relationship. Our business office will answer any questions about our fees or your financial responsibility, please call (406) 752-7900.

Your Financial Responsibilities

You are ultimately responsible for the payment on your account. Our practice will file insurance claims for all reimbursable services to both your primary and secondary insurance carriers. Please remember that you are responsible for copayments, coinsurance, deductibles, durable medical equipment, form fees and non-covered services. We accept payment by cash, personal checks, Visa, MasterCard, Discover and American Express. You will receive statements from our office for account balances that are your responsibility; the balance is due within 30 days. If the patient portion of your account is not paid in a timely manner collection efforts will be made. **You understand that should you default on payment of your account, and collection agency services are required, all costs of collections up to 40% of the balance, including attorney/court costs, will be added to the balance of your account.**

Health Insurance

Our practice participates with most private insurance plans. Please provide us with your complete insurance information and bring your insurance card to all of your appointments. As a courtesy, we submit the claim on your behalf and make every effort to resolve any billing problems that arise. Your insurance may REQUIRE that we collect your designated co-pay, at the time of service. **Please be prepared to pay these at each visit along with any outstanding balances.** **Referrals and Pre-authorization:** It is the patients' responsibility to obtain referrals and pre-authorization required by your insurance carrier and accept liability for charges should your insurance carrier deny benefits.

Medicare

We will submit to Medicare for the Medicare allowed amount. You are responsible for the deductible, co-pay and co-insurance which may be billed to a secondary insurance if you have one. All patient balances remaining after Medicare and secondary insurance payment will be billed to you and will be due within 30 days.

Workers Compensation

If you are injured through your employment, we will file your Worker's Compensation or Insurance Claim. You must provide us with a claim number, name of the carrier, the date of injury, employer at time of injury, and the part of the body injured to enable us to obtain proper authorization to provide treatment and submit your claim. Without this information, you the patient will be held responsible for all charges.

Accidents

Accident cases require the date of injury, insurance company, claim number and contact person from the insurance company. **Patients shall be responsible for medical services related to an accident. We reserve the right to lien patient recoveries from legal or insurance settlements for unpaid charges when permitted by law.**

Self Pay

If you do not have insurance, we expect payment in full at the time of service. A 15% discount will be honored for payment made at the time of service. If you cannot pay in full, you will need to contact our billing department to establish payment arrangements.

Surgery and Advanced Imaging

For scheduled surgical procedures (including injections) and advanced imaging (MRI), a deposit of 50% of the estimated patient's responsibility is required **PRIOR** to the scheduled procedure. The component for reading the MRI will be billed separately. This statement will come from Northwest Imaging. If you have any questions regarding the costs of the reading for the MRI, you can contact them at 406-752-5656, ext.285

Form Completion/Medical Records Requests

There will be a \$15.00 administrative fee to be paid prior to completion and release of forms such as disability and FMLA. We charge a nominal fee for the copying of medical records and x-rays.

Authorizations

*I authorize the release of any medical information necessary to process insurance claims.
I authorize my insurance benefits to be paid directly to Flathead Valley Orthopedic Center, P.C. dba Flathead Orthopedics
I authorize release of information to my employer if this is a work related condition.*

I have read, understand and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments, coinsurance, deductibles, durable medical equipment and form fees are my responsibility and must be paid within 30 days unless other provisions are in place.

Copy Offered (initial): Accepted _____ Declined _____

Date _____

Signature of Patient or Responsible Party