# Financial Policy

Thank you for choosing Orthopedic Surgery Center as your facility for your healthcare. 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) 257-6700 to speak with our helpful business staff.

## Surgery

For scheduled surgical procedures (including injections), a deposit of 50% of the estimated patient's responsibility is required **PRIOR** to the scheduled procedure.

## Your Financial Responsibilities

You are ultimately responsible for the payment on your account. Our facility will file insurance claims for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for copayments, co-insurance, deductibles 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. **Any collection agency fees or other expenses incurred to collect the patient portion of your account will be at your expense. Once an account has been sent to an outside collection agency the amount due must be paid in full prior to any appointments.**

## Health Insurance

Our facility is contracted with Medicare, Medicaid, Blue Cross/Blue Shield of Montana and several other carriers. A list is available upon request. Please provide us with your complete insurance information, and bring your insurance card to 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 **REQUIRES** that we collect your designated co-pay, at the time of service. **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.

## 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 and 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.**

## Non-Contracted Insurance

OSC will not accept "usual and customary" fee schedule from non-contracted insurance carriers. OSC will balance bill the beneficiary of *non-contracted* insurance plans for unpaid charges. OSC offers a 10% discount on patient responsibility after insurance if balance is paid within 30 days from procedure.

## Self Pay

We expect prompt payment for services rendered. We offer a 25% discount for self pay individuals if paid within 30 days of the procedure. If you cannot pay in full, you will need to meet with our business office.

**Authorizations**

***I authorize the release of any medical information necessary to process insurance claims.***
***I authorize my insurance benefits to be paid directly to Orthopedic Surgery Center, LLC.***
***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 copays and deductibles, are my responsibility and must be paid within 30 days unless other provisions are in place.

Copy Offered: (Please initial) Accepted __________ Declined ___________

________________________________________________ Date ____________________________

Signature of Patient or Responsible Party