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 – press 2 to speak with our helpful business staff.

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, 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 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 **REQUIRES** 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 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.**

Self Pay

If you do not have insurance we expect payment in full at the time of service. A 10% discount off regular fees is offered for payment made at the time of service. If you cannot pay in full, you will need to meet with our business office.

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.

Forms Completion/Medical Records Requests

There will be a $15.00 charge 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 Orthopedic Center, P.C.
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: Accepted __________ Declined ___________

____ Date ____________________________

Signature of Patient or Responsible Party