

MEDICAL INSURANCE COVERAGE AND FINANCIAL POLICY

For our patients who have medical insurance, we will be happy to submit your claims for services rendered. **Your copayment is due at the time of service.** As we deal with many insurance companies, we cannot have full knowledge of each carrier's particular benefits, or each patient's terms of coverage. **Please bring the most current copy of your insurance card AND a picture ID. We cannot accept altered copies of Medicare or insurance cards. If you have altered your card in any way, you will be required to pay in full on the day of service.**

Although we are contracted providers for some insurance companies, there are many with whom we are not contracted. In that instance, **PAYMENT IN FULL is due at the time of service. If you do not have any insurance coverage, payment in full is due at the time of service.** We will submit your insurance claims for you; however, it is the patients' responsibility to follow up with their insurance company should any payment issues arise.

If you are covered under a group policy provided by an employer, the personnel department can provide you with a comprehensive explanation of your benefits and coverage. It is the policyholders' responsibility to know the limits and terms of their coverage; **ultimately, the policyholder is responsible for all fees incurred.**

Insurance Terms

Co-Payment: This is usually a **flat fee** due when a patient sees a physician; some policies do not have a copay and all charges are subject to the deductible.

Deductible: This is the amount due by a patient before insurance covers a charge. Office visit charges may be subject to deductible or have a copay. Often, additional services such as urinalysis, x-rays, casting, etc. may be subject to deductible.

Co-Insurance: This is a **percentage** due by the patient for services rendered after a deductible has been met. Some plans pay 90%, and the patient pays 10%. Others pay 80% or 70%, and the patient pays 20% or 30%, respectively, until the out of pocket maximum has been met.

Allowable Charge: The amount a practice has agreed to accept in payment for services, per its contract with the insurance company.

Your copayment is due at the time of service. However, it may not be the only thing you will ultimately owe. After insurance has processed your claim, you may receive a billing statement from us showing that you owe additional money because some charges were applied to your co-insurance, deductible, a non-covered service, or a service that was not a benefit.

Our policy has always been to help our patients utilize their insurance coverage. Under no circumstances will we allow insurance companies to compromise or dictate the level of quality medical care provided to our patients or the fees required to support that level of care.

We value each and every patient who comes to us for medical care. It is important to us that you take an active part in your medical care as well as the financial responsibilities associated with that care. If you have any questions before or after seeing our physicians as a patient, please do not hesitate to speak with a member of our office staff.

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted this financial policy. We are dedicated to providing the best possible care and service to you and regard your complete understanding and acceptance of your financial responsibilities as an essential element of your care and treatment.

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Unless other arrangements have been made in advance by either you or your insurance carrier, **full payment is due at the time of service, including any Medicare deductibles or copayments.** For your convenience we accept cash, check, Visa, MasterCard, and Discover. The fee for a check returned by the bank for insufficient funds is \$35.00.

We will bill your insurance carrier for all Rivergate Orthopedics and Animas Urology physician services provided to you at Mercy Medical Center and the Animas Surgical Hospital, and any balance due is your responsibility and is due upon receipt of a statement from our office for any unpaid charges. There may also be additional charges, such as laboratory, Xray, pathology, anesthesiology, and/or a facility fee, which must be paid to the rendering facility or physician.

If a balance on any account remains unpaid after 45 days, that account may be sent to a collection agency. The patient/responsible party will then be responsible for the amount due plus all costs of collection, including but not limited to:

- *All collection expenses charged by the collection agency
- *An 18% interest charge on all unpaid balances
- *Court costs and Attorneys' fees
- *Any discounts previously applied to the account may be reversed

If your account is sent to a collection agency, you will not be seen by this practice, even for emergencies. Prepayment by cash or credit card will be required for any incurred charges.

Minor Patients

For all services rendered to minor patients (under 18 years of age), we will look to the adult accompanying the patient for payment. Custody agreements are not a consideration of this practice.

FINANCIAL INTEREST STATEMENT

Dr. Mark Forrest and Dr. Jennifer Forrest have a financial interest in the Animas Surgical Hospital LLC, which is a private, for-profit organization. As such, there is a financial incentive to order tests and perform surgeries and procedures at this hospital.

Statement of Responsibility, Assignment of Medical Benefits & Authorization for Release of Information

It is the policy of this office to have patients pay for services in the office on the day they are rendered.

I agree that if I or my minor children are covered by insurance, and if my carrier does not pay in full for services any one of us receives through Rivergate Orthopedics and Animas Urology, PC, that I am personally responsible for payment of this balance within 15 days of billing.

I understand that if any unpaid portion of my balance becomes delinquent, it may begin to accrue interest at 18% per annum. In the event my balance becomes delinquent and further collection efforts are necessary, I agree to pay all costs and reasonable attorneys' fees incurred by Rivergate Orthopedics and Animas Urology, PC, in said collection efforts.

All demographic information provided by me to Rivergate Orthopedics and Animas Urology, PC, on this and other forms represents my permission to use said information to contact me, designated family members, or designated others.

My signature below represents my understanding and acceptance of this policy. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I hereby authorize the release by Rivergate Orthopedics and Animas Urology, PC, any medical information necessary to process any claim or appeal on my behalf, or to another physician or facility for continuation of my medical care, or to me for my personal record.

I agree to comply with the above Medical Insurance Coverage and Financial Policy, revised 9/2016.

Advance Beneficiary Notice (ABN)

You need to make a choice about receiving health care items or services. It has been our experience that health insurance companies sometimes will not pay for health care items or services, even when these items and/or services are medically indicated and have been coded and billed appropriately. The fact that your insurance company may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you do not understand why your insurance company may not pay.
- Ask us how much these items or services will cost you.

If you wish to receive health care services through this office, please read the statement below and sign and date this advance beneficiary notice.

I understand that my insurance company will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance company. If my insurance company does pay, you will refund me any payments I made to you that are due to me. If my insurance company denies payment, I agree to be personally and fully responsible for payment. I forego any claim to payments made, and will pay for services received if not paid for on the date of service. I understand I can appeal my insurance company's decision.

SIGNATURE

DATE

Signature will be obtained in the office on our electronic signature pad.

