Orthopedics New England Policy

Thank you for choosing us as your Specialty provider. We ask that you carefully read and sign the following Financial and Privacy Policy.

****We require a copy of ALL Insurance cards and ask that you present them at your first visit.**

Participating Insurances

We participate with many, but not all insurance companies. Co-pays are due at time of service**. If a co-payment is not made at the time of service, a $10.00 service charge will be added**.

For all Insurances

Please review your benefit listing summary that you received from your insurance company to understand your coverage. If your Insurance changes, it is your responsibility to notify our office.

Non Participating Insurances, Self Pay

Payment in full is required at the time of each service. Fees are available upon request.

Non-Copayment Plans

If your plan does not require a co pay and we participate, you are responsible for any deductible and balances that your plan indicates on the explanation of benefits.

Referral from Your PCP

If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your visit and present it when you check in for your appointment

Missed appointments

It is the policy of this office that after two missed appointments, you will be charged for your 3rd missed appointment if you do not cancel at least 48 hours in advance. The missed **appointment charge for your 3rd missed visit will be $75.00 due and payable before any future appointments will be made.**

**** PLEASE NOTE WE DO NOT CALL TO CONFIRM SCHEDULED APPOINTMENTS****

Medical Records

The fee for a complete medical record is $15.00. The fee for a copy of an x-ray cd is $5.00. Please allow 14 business days for processing the medical records before calling to check the status of your request.

Account Balances and Collection Procedures

You're responsible for timely payment of your account. Your balance is due in full unless a previous payment agreement has been made. Orthopedics New England reserves the right to reschedule or deny a future appointment on delinquent accounts. If sent to collections, you will be required to pay your balance in full before re-entering the office**.**

Returned check fee is $30.00.

Payment methods of cash, checks, MasterCard or VISA are accepted.

By signing this form I acknowledge the receipt of Orthopedics New England's notice of Privacy Practices which provides me with detailed information about how they may use and disclose my protected health information for the purposes of treatment, payment, and health care operations. I can also obtain a copy at http://www.orthopedicsne.com/about/privacy-security.

I understand and agree that insurance policies are an agreement between an insurance carrier and myself. I understand that this office will prepare and necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I authorize Orthopedics New England to furnish information to insurance carriers concerning my illness and treatments.

Patient Name _____Date _____

Patient Signature_____Date _____

Standard Waiver of Liability

I understand that my Managed Care Plan requires that my Primary Care Physician authorize and complete a referral for visits to a specialist. If this procedure has not been followed and the appropriate referral is not in the office at the time of visit, I will be held accountable for payment for this service, or may reschedule until said referral is in place.

Patient Signature: _____ Date: _____