



FINANCIAL POLICY

We accept cash, check, Visa, MasterCard, Discover, American Express and most insurance programs.
WE DO NOT ACCEPT MEDICAID OR ANY STATE-ASSISTED PROGRAMS.

IF THE PATIENT IS COVERED BY INSURANCE, THE FOLLOWING APPLY:

- The patient/responsible party or guarantor signing below ("you") must provide us with current and correct information about the patient's medical coverage/insurance/health plan (health plan).
- We file group health plan claims and by law, must file Medicare claims.
- **You must follow the rules of your health plan such as providing a valid referral form** and precertification of testing and/or surgery when required by the health plan for payment. We will assist with this process, but if claims are denied because of your failure to comply with coverage/payment rules, **you will be responsible for paying the denied claim(s).**
- You are responsible for paying any deductibles, co-payments, non-covered services or other costs not covered by the health plan at the time of service.
- Amounts are due for a child regardless of parental custody, divorce or separation terms.

WORK RELATED INJURIES

- If you have submitted an injury to your employer **AND** the employer has approved treatment, you will not be charged or billed for medical services. Disability form completion is **not** included and the \$40 fee **is due by you.**
- If the patient's employer does not approve treatment and **YOU SELECT US FOR YOUR TREATMENT**, you may be billed and you may be responsible for payment of service not approved by the employer.

LIABILITY OR LEGAL CASES

- If the patient is involved in a claim or lawsuit that affects the payment of our services, we hold you responsible for prompt payment of our regular fees.

CONTACT **NIMBLE SOLUTIONS** (OUR BILLING OFFICE) AT (314) 930-3619 IF:

- You think your bill is wrong or if you need more information about an item on your bill,
- You need to arrange an alternative payment plan for your financial obligation.

COLLECTION FEES

- In the event of non-payment, you will be responsible for any legal and collection fees. Legal/Collection fees are **in addition** to the outstanding balance and will apply should the account be referred to an outside agency.

CONSENT TO TREAT

I consent to Central Orthopedics and Sports Medicine physicians, their assistants and other staff to provide medical and/or surgical treatment, testing, supplies, medications, services, equipment and other items deemed necessary for my treatment. I have been informed of the nature and purpose of the proposed treatment, common side effects, risks, benefits, alternatives and estimated duration of treatment as applicable. I understand that I may withdraw consent to treatment and will inform the physician of any decision to terminate treatment. In the event of an emergency while receiving care at Central Orthopedics and Sports Medicine I authorize Dr. Thomas, Dr. Brown, Tracy Rush and their staff to arrange for care and treatment necessary to address the emergency medical conditions.

ASSIGNMENT OF BENEFITS

I acknowledge that the patient or guarantor signing below is financially responsible for all charges for medical services provided by Dr. Thomas, Dr. Brown or the nurse practitioner, Tracy Rush and payment is due on the date of service. If an insurance/health plan claim are filed by Dr. Thomas, Dr. Brown or Tracy Rush, I request that payment of all benefits be made directly to **Central Orthopedics and Sports Medicine**. I agree to pay for any services, or out-of-pocket expenses which are not covered by insurance. I acknowledge receipt, and acceptance of Central Orthopedics and Sports Medicine’s financial policies as set forth on this form.

Printed Patients Name

Patient Signature

Date

Printed Legal Representative or Guarantor Name

Legal Representative or Guarantor Signature