



ORTHOPEDIC SURGICAL PARTNERS
ORTHO SPEED PASS

Financial Policy

As a patient of Orthopedic Surgical Partners, you are required to consent to our Financial Policy. We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at anytime. Your clear understanding of our Financial Policy is important to our professional relationship.

FORMS OF PAYMENT: We accept Cash, Check, Money Order, Visa, MasterCard, Discover and American Express. A returned check fee of \$35.00 per check returned from your bank for non-payment or insufficient funds is assessed to a patient's account.

"NO SHOW" FEES: There is a \$25 "no show" fee for an office appointment not cancelled within 24 hours. A "no show" for a surgical procedure is \$100.

COPAYMENTS: Your insurance REQUIRES that we collect your designated co-pay **at the time of service**. Please be prepared to pay the co-pay at each visit. Without it, you may be required to reschedule.

OUTSTANDING BALANCES: All outstanding balances are the responsibility of the patient. If you have been billed more than once without payment, you may be unable to schedule an appointment or be required to reschedule an existing appointment. Chronic non-payment of your outstanding balances can constitute severance from the Practice.

ESTIMATED SURGICAL DEPOSITS: Should you decide or require surgery, you are responsible for any and **ALL** fees, such as co-pays, co-insurance, deductibles or out-of-pocket expenses for our surgeon's fee, which your insurance company makes you responsible for. Our practice requires payment of these fees prior to your surgical procedure. Our Billing Department will contact you with information pertaining to the amount you are responsible for. Please note: our fees are separate from the hospital or ambulatory surgical center and the anesthesiologist. Refusal to pay these fees can result in rescheduling or cancellation of your surgery.

URGENT CARE/WALK-INS: As a courtesy to our patients, we accept most Insurances. If we do not accept your insurance, there is a flat \$275 Office Visit fee. This fee includes your time with the Provider, the exam and new radiology exams or review of any outside radiology exam reports. Any services over and above would be charged additionally with a discounted rate similar to those provided to Insurance if paid in FULL at the time of the visit. Examples of additional charges would be injections, braces, casts, splints, fracture care plan management, etc. Contact our Billing Department directly at 860-525-4469 opt 5 with any questions.

INSURANCE REFERRALS: If your insurance plan requires a referral from your Primary Care Physician it is **YOUR** responsibility to obtain the referral prior to your appointment and to have it with you at the time of the appointment. If you do not have your referral, you may have to reschedule your appointment.

NON-PARTICIPATING INSURANCE PLANS or "OUT OF NETWORK": I understand if I elect to be treated by any provider at Orthopedic Surgical Partners who does not participate in my insurance plan, I am directly responsible for my balances, and may not be reimbursed by insurance. Further, I understand I am responsible for care not covered by my insurance plan, such as DME or Orthotic devices.

I have read and understand the Financial Policies of Orthopedic Surgical Partners and agree to comply with this Financial Policy.

Patient Name (Please Print)

Patient Signature (or Representative Guarantor)

Date