Patient Financial Policy

Thank you for choosing Greenleaf Orthopaedic Associates! We are committed to the success of your medical treatment and care. Should you have any problems after hours you may reach our on-call physician by calling (847)-623-3090. Please understand that a mutual financial understanding is part of our relationship.

We sincerely hope that by sharing our financial expectations we will strengthen the physician-patient relationship and keep the lines of communication open. This financial policy helps us provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact our billing department at 847.623.3090.

Payment is Due at the Time of Service

- We accept cash, checks, debit, and all major credit cards.
- All copayments and fees for non-covered services are due at the time of service.
- Insurance required copayments are due when you check in for your appointment. If you arrive without your copayment, we will need to reschedule your appointment.
- Patient-responsible balances are due when you check in for your appointment, regardless of receiving a statement.
- In the event you need surgery we will provide you an estimate of your insurance required deductible and coinsurance amounts, and a deposit in that amount is required prior to surgery.
- We request that at least **24 hour** advance notice be given to the office if you will be unable to keep your scheduled appointment. This allows us to release your appointment time to another patient. Patients who repeatedly "no show" for appointments may be discharged from the practice.

Proof of Insurance

- Please bring your insurance card(s) and a valid State or government issued photo ID with you to each appointment.
- It is your responsibility to notify the Practice of changes in your health insurance.

Self-Pay Accounts

- We designate accounts, **Self-Pay**, under the following circumstances: (1) patient does not have health insurance coverage (2) patient is covered by an insurance plan that our providers do not participate in, (3) patient does not have a current, valid insurance card on file or (4) patient does not have a valid insurance referral on file.
- Self-Pay patients, please be prepared to pay a minimum of $300.00 on the date of service and supply a valid social security number. There may additional fees for in office procedures, x-rays, crutches, splints, castings, DME or other supplies or services. If you are unable to pay, please ask to speak to the billing department.

Worker's Compensation

- We will bill any Worker's Compensation insurance carrier providing we have prior authorization. We are unable to schedule an appointment for a patient under any of the following circumstances: no prior approval, disputed or denied claim, or you are in the process or considering filing a claim. In these situations, we will invoice your health insurance carrier. In the event your compensation claim is disallowed you are responsible for payment for all services rendered. Any employer wishing to pay for treatment needs to pay in full at the time of service, we do not bill employers.

Referrals

If you have an HMO plan we are contracted with, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, call your primary care physician to obtain it. Without an insurance required referral, the insurance company will deny payment for services. As such, <u>if you are unable to obtain the referral at that time, you will be rescheduled</u> or asked to pay for the visit in advance.

Our Responsibility to Report Non-Compliance

It is our obligation under many of the insurance contracts to report patients who: repeatedly refuse to pay copayments/deductibles at time of service, or who repeatedly "no show" for scheduled appointments.

Divorce and Child Custody Cases

- In cases of divorce, the individual who receives care is responsible for payment of co-payments, coinsurance, deductibles, and nonparticipating insurance balances at the time of service. We will not bill a divorced spouse for the patient's services.
- The parent who brings the child to the office for care is responsible for payment at the time of service no matter if the account is self-pay, participating insurance, or nonparticipating insurance. The Practice does not honor divorce specifics (*e.g., percentage of financial responsibility).*
- If the child has coverage with a participating insurance plan and the proper insurance identification is present at the time of service, the Practice will bill that insurance company. Applicable copayments are due at the time of service.

Billing, Payments and Refunds

- We require a credit card authorization on file as a method of payment otherwise a minimum deposit of $300.00 will be required. Please reference the Patient Balance Payment Agreement for further details.
- Your balance is due in full within 14 days of the statement date.
- If you cannot pay the balance in full with 14 days, please contact our billing department.
- If full payment is not made or no contact is made to the billing department, the credit card on file will be charged according to the payment agreement.
- It is your responsibility to notify the office of any change in address, phone, employment, or insurance coverage.
- If you make an overpayment on your account, we will issue a refund only if there are no other outstanding debts on other accounts with the same guarantor or financial responsible party.
- We reserve the right to report delinquent accounts to credit bureaus, assess a collection fee, take other collection action, or terminate you as a patient of this Practice.

Greenleaf Orthopaedic Associates is committed to providing quality healthcare to all of our patients in the most cost-effective manner. We are sensitive to the needs of our uninsured patients as well as our patients who are experiencing financial hardships.

Payment Plan- Our payment plan is intended for our patients who may need to pay their balance over several months, whether you are uninsured, have a high deductible or high coinsurance. Please note that copayments are due at the time of service. We ask for a minimum 50% of the entire balance at the time of the visit and then 10% of that remaining balance paid monthly. We offer recurring billing – whereby your credit/debit card is charged on an agreed date and amount. This saves you the hassle of writing a monthly check and allows us to keep the costs down.

Initial here ______ I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by insurance, as well as applicable copayments, deductibles and coinsurances, are my responsibility.

Initial here ______ I authorize my insurance benefits be paid directly to **Greenleaf Orthopaedic Associates.**

Initial here ______ I authorize **Greenleaf Orthopaedic Associates**, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

Initial here ______ I authorize **Greenleaf Orthopaedic Associates** to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Initial here ______ I authorize **Greenleaf Orthopaedic Associates** to contact, discuss my personal health information with:

Name: ______________ Relationship ______________ Phone Number ______________

Emergency Contact ______________ Relationship ______________ Phone Number ______________

Primary Doctor: ______________ Phone Number: ______________

***Patient/Guarantor Signature** ______________________ **Date:** ______________

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have reviewed or received or have been given the opportunity to receive a copy of **Greenleaf Orthopaedic Associates** Notice of Privacy Practices.

***Patient/Guarantor Signature** ______________________ **Date:** ______________

Patient Name: ______________________ Date of Birth: ______________

Responsible Party/Parent Address ______________________________

Apartment/Unit: ______________ City: ______________________ Zip: ______________

SSN: ______________ Home Phone: ______________ Cell: ______________

Employer: ______________________ Work Number: ______________

Email Address: ______________________________

I prefer to be contacted at ☐Home ☐Cell ☐Work **It is Ok to Leave messages at ☐Home ☐Cell ☐Work**

Primary Insurance Company Name: ______________________________

Policy Holders Name: ______________________________ ☐Same as Patient

Birthdate: ___/ ___/ _____ SSN: ______________ Relationship to Patient: ______________

Insured's Employer Name: ______________________ Phone: ______________

Secondary Insurance Company Name: ______________________________

Policy Holders Name: ______________________________ ☐Same as Patient

Birthdate: ___/ ___/ _____ SSN: ______________ Relationship to Patient: ______________

Insured's Employer Name: ______________________ Phone: ______________

How did you hear about us?

☐Primary Doctor ☐Internet ☐Family Member/Friend ☐ Health Fair ☐ Fun Run/Marathon

☐Lake Forest Hospital ☐ Advocate Condell Medical Center ☐ Advocate Condell Advertising

Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Refused to report

Primary Race: ☐ Caucasian ☐ Hispanic ☐ African American ☐ Asian ☐ American Indian ☐Native Hawaiian ☐ Other Pacific Islander ☐ Other Race ☐ Refused to Report

Language: ☐ English ☐Spanish ☐Indian- Hindi ☐Russian ☐Other