## Patient Balance Payment Agreement for Greenleaf Orthopaedic, S. C. (and Physical Therapy)

Our practice is acutely aware of the ever escalating health care costs and we are doing everything feasible to help lower costs through increased efficiency. Recent changes in health care benefits have resulted in larger patient co-pays, deductibles and co-insurance.

As a service to our patients, we call the primary insurance company prior to a scheduled surgery and a first visit to physical therapy to verify eligibility, obtain deductible, co-pay, and co-insurance amounts and the procedures requiring pre-authorization. However, we cannot guarantee that the information given to us by the insurance company constitutes guarantee of payment. Ultimately, it is the patient's responsibility to verify and understand his/her insurance coverage.

It is costly and inefficient to send patients a monthly statement. We request that you assist us in helping to reduce billing costs by completing the credit card authorization below. By signing the authorization, you can be assured that your credit card information will be securely stored and charged only for those fees your insurance company does not pay. We honor all contractual obligations with insurance companies with which we participate. You will never be charged in excess of the allowed amounts.

For those patients who would prefer to pay their balance by check, a debit card, or another credit card once we know your balance, we will mail you one statement for the full amount due. Full payment will be due in 30 days (if payment is not received in 30 days, the credit card you have on file will be charged the full amount due **after** insurance has paid its portion).

We accept checks under these conditions: When you pay by check, if your check is returned for any reason, you expressly authorize Greenleaf Orthopaedic, S.C. (and Physical Therapy) to debit your account for the amount of the check plus a processing fee of $30.00. The use of a check for payment is your acknowledgement and acceptance of this policy.

## Credit Card Authorization

I hereby authorize Greenleaf Orthopaedic, S.C. (and Physical Therapy) to charge my HSA/HRA, debit, or credit card for any balance for which I am legally responsible, including deductibles, co-pays, co-insurance, non-covered items, and any applicable fees associated with the cancellation policy.

***(Please sign and date this agreement, then present your credit card to receptionist)***

Patient Name: _____

Name of Cardholder: _____

**Type of Card on File (Circle One): HSA Card Flex Card Visa MasterCard Discover**

(We apologize for any inconvenience however we do not accept American Express)

Last Four of Credit/Debit Card Authorized: _____ Expiration Date: _____

Signature: _____ Date Signed: _____

*(Please give a copy to patient)*