CONSULTING ORTHOPAEDIC ASSOCIATES
A DIVISION OF THE ORTHOPAEDIC NETWORK, INC.

FINANCIAL POLICY

All office visits should be paid for at the time of the visit (exceptions are Worker's Compensation cases with a valid claim number on file, HMO's for which we are providers and Medicare patients). Co-payment amounts are due and payable at the time of service. We charge a $10.00 billing fee if your co-pay is not paid at the time of service.

All Worker's Compensation patients seen in this office for the first time are responsible for the visit and x-rays unless patient has a claim number and diagnosis code which the claim is allowed for in writing.

All charges for services incurred will become due and payable 45 (forty-five) days from the service date. This period of time allows sufficient time to process insurance and to make payment in full of any balance remaining after payment by the carrier (exceptions to this policy would be the same as listed above).

All patient balances over $200.00 remaining after insurance payments must be paid in full within 60 days unless other arrangements have been made with the office.

We require a 24 hour notice of cancellation of your office visit. There will be a no show fee of $25.00 charged to your account if notice is not given. This must be paid prior to rescheduling another appointment.

Insurance forms for services rendered will be completed and mailed to respective insurance carriers as a service to our patients. If payment has not been made by the insurance carrier, it is the patient's responsibility to contact the insurance company to check the status of the payment. The balance of your account is your responsibility.

For our Medicare patients, we have joined the Federal Medicare Participating Physician Program. We will accept assignment on all services covered by Medicare. You or your secondary insurance carrier will be responsible for approximately 20% of the Medicare approved fee. This office will bill Medicare; we will then bill you or your secondary carrier. In the case you have Medicare as your secondary insurance, please notify this office.

I have read, understand and agree to comply with the above outline policy.

X _____ Date _____

Name (Signature)

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960 W. WOOSTER STREET ♦ STE.110 ♦ BOWLING GREEN OH 43402 ♦ (419) 353-6866