Maurice Jove M.D. Jeff Traub M.D. Scott Barbour M.D. Brian Vanderhoof D.O.

FINANCIAL POLICY

Patient Name _____

FOR PATIENTS WITH HEALTH INSURANCE: We bill most insurance carriers for you. We also bill most secondary insurance companies for you. Co-payments are due prior to service. Deductibles are due at the time of service. If your insurance requires a referral, it is your responsibility to be sure the referral is at our offices and valid prior to each appointment. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid nor why it paid less than anticipated. If an insurance carrier has not paid within sixty days (60) of billing, the balance is due in full from you.

WORKERS COMPENSATION PATIENTS: If you injury is work related, we will need the case number, contact information, and authorization prior to treating you.

PERSONAL INJURY / AUTO INSURANCE: We will file insurance with Auto carriers if it is with ***your*** carrier. We will ***not*** file a third party claim. If this is the situation, you may pay us in full for services, we will issue a receipt, and you may get reimbursed from the auto carrier. We will ***not*** file health insurance in lieu of Auto policy. Once your benefits are exhausted, we may, at our discretion, sign an attorney lien. In all circumstances, you, the patient, are responsible for the charges. If you present us with health insurance and then subsequently receive a settlement, we reserve the right to recover, from you, any adjustments made to your account.

ATTORNEY LIENS: We evaluate all Attorney Lien requests individually; if we accept the Lien, both yourself and the Attorney must sign the Lien. In the event you terminate that relationship, fees are due immediately.

MISSED APPOINTMENTS: We reserve the right to charge you for appointments that are not cancelled. Repeated misses, not cancelled appointments, may result in the dismissal from our practice.

SURGERY FEES: Prior authorization for surgery is required for many procedures. Our office will obtain that on your behalf. Co-payments, deductible, and patient responsibilities are due at the pre-operative visit unless other arrangements are made prior. We will verify the benefits and give you an approximate amount due. This is based on what we anticipate the procedures will be, if there are additional or less procedures performed, we will bill you for any remainders or issue a refund once the insurance has paid their portion. Assistant surgeons are required for the following procedures:
Total Joint Replacements, ACL Reconstruction's, certain types of fracture management, and "open" cases. We will inform you whether or not an assistant surgeon is anticipated. In these cases, you have the responsibility to pay a maximum of $500.00 toward the cost of the Assistant Surgeon. If your insurance company issues payment to us we will issue you a refund up to your $500.00.

SIGNATURE ON FILE AND ASSIGNMENTOF BENFITS: I request payment of authorized benefits, Medicare or otherwise, to be made on my behalf to the provider of services. I authorize the holder of information about me to release to the carrier, Health Care Financing Administration or otherwise, and its agents, any information needed to determine these benefits or benefits payable to related services. I understand my signature requests payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in ITEM 9 of the CMS 1500 form or elsewhere on other approved forms and electronic submitted claims, my signature authorizes release of information to other insurer or agency. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is only responsible of the deductible and co-insurance. Co-insurance and deducible are determined by the carrier. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as an original. I understand I am responsible for the bill at the time of service unless assignment has been accepted. I FURTHER UNDERSTAND THAT IT IS MY RESPONSIBILITY TO MAKE SURE MY INSURANCE COMPANY HAS PAID THE CLAIM OR I ACCEPT RESPONSIBILITY TO PAY THE CHARGES IN FULL. I have read and understand, have had the opportunity to ask questions, and agree to the financial policy for payment of professional fees.

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Signature of Patient (or guarding if under 18 years old) Date

GWINNETT BONE & JOINT SPECIALISTS
GEORGIA KNEE & SPORTS MEDICINE
GWINNETT ORTHOPAEDIC & SPORTS MEDICINE