



FINANCIAL POLICY

Thank you for choosing The Hughston Clinic, PC as your Orthopedic specialty healthcare provider. We are committed to providing you and your family with the best available medical care. In our ongoing process to make sure that all your medical needs are met, our staff will be available to discuss our fees and this policy with you. The services you have elected to participate in imply a financial responsibility on your part.

We ask that all responsible parties read and sign our financial policy as well as complete the patient information forms prior to seeing the physician.

Payments for all services will be due at the time services are rendered. In order to serve you better, we accept cash, check, Visa, MasterCard, Discover, and American Express. As a courtesy to you, we will verify your coverage and bill your insurance carrier on your behalf; however, you are ultimately responsible for the entire bill. As the responsible party, please understand:

(PLEASE INITIAL THE FOLLOWING)

_____ 1. Your insurance policy is a contract between you, your employer (if applicable), and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance and “usual and customary” charge. As your medical provider, we will only supply factual information to facilitate claim processing.

_____ 2. Fees for services, which include unpaid balances, deductibles and co-payments and in some cases coinsurance, are due at the time of service. Returned checks and unpaid balances may be subject to collection placement and collection fees.

_____ 3. All charges are your responsibility whether your insurance company pays or does not pay. If your insurance carrier does not remit payment within sixty days, the balance may be due in full from you. If any payment is made directly to you for services billed by The Hughston Clinic, you recognize an obligation to promptly remit payment to The Hughston Clinic, PC.

_____ 4. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by The Hughston Clinic, PC, I will be responsible for all costs of collecting monies owed, including collection agency fees.

_____ 5. The above does not apply for those patients that are considered Workers’ Compensation. However, be advised that as a compensation patient you may be held responsible for charges in the event that your claim is denied or not paid or determined not to be work related.

____6. Our practice utilizes the services of Assistant Surgeons/Physician Assistants for medical services including surgical procedures. As with the other professional services we will bill your insurance for these services; however, should your insurance not cover the charges you may be held ultimately responsible.

____7. The completion of disability and/or FMLA forms are not billable/reimbursable by insurance carriers, therefore fees are your responsibility for payment. Hughston Clinic fees related to completion of these documents are expected to be paid upon presentation of forms for completion.

We understand that financial problems may affect timely payment, so we encourage you to communicate any such problems to us, so that we may assist you in keeping your account in good standing. Our financial counselor is available to assist you or answer any questions you may have.

I UNDERSTAND THE ABOVE INFORMATION AND WILL BE RESPONSIBLE FOR THE PATIENT LISTED BELOW

Printed Name of Patient: _____

Signature of Patient or Responsible Party

Date

Relationship if other than the patient