FINANCIAL POLICY

Southwest Shoulder, Elbow and Hand is committed to the success of your medical treatment and plan of care. Because patients are ultimately responsible for the charges associated with their care, even when insurance is in place, you may find the following information helpful. We realize you have choices for your medical care and appreciate your choosing us for your healthcare.

PATIENT RESPONSIBILITIES

You can help ensure an efficient experience by assisting with the following:

- Providing us with your picture identification, insurance card and Social Security number to enable us to submit your claims timely and accurately.
- Knowing your insurance benefits and limitations such as contracted physicians with their plan, covered and non-covered benefits, authorization requirements, deductibles, co-insurance, and co-pays. We recommend you contact your carrier directly with any questions pertaining to your coverage.
- Ensuring there is a ***referral or authorization*** for our providers to treat you if it is required by your insurance. Please check with your insurance if a referral or authorization is required and whether a paper referral is sufficient or if the referral must be completed online, this is the patient's responsibility, along with their PCP, to avoid unexpected costs.
- Providing us with copies of any pertinent medical records, including tests and x-rays (MRI/CT/Arthrogram)
- Paying your estimated portion of the charges at the time of service. If you are unable to pay your estimated responsibility at the time of service, you may be required to reschedule your appointment.
- Paying any additional amount owed, when due and maintaining a current account at all times
- Providing us with at least 24 hours advance notice should you need to cancel or reschedule an appointment.
- Please note that co-payments, co-insurance, and deductibles are a contractual agreement between you and your insurance carrier. We cannot change or negotiate these amounts.

INSURANCE INFORMATION

We will bill your primary and secondary insurance carrier in a timely manner. Please note that co-payments, co-insurance, and deductibles are a contractual agreement between you and your insurance carrier. We cannot change or negotiate these amounts. We will bill you or refund you according to your obligation as stated by your insurance carrier.

Deductibles/Co-Insurance – A pre-payment of all applicable fees are required for all services including elective, non-emergent procedures prior to the surgery being performed. Your out-of-pocket cost is estimated based on your benefits and our fees and is an "estimate"; final fees will depend on the processing of your claim from your insurance carrier. Anesthesia and other providers are separate fees and are not handled by our staff.

Non-Participating Insurance – If we do not participate in the insurance you have, we will file a claim as a courtesy. All unpaid claims will become your responsibility 45 days following filing and be immediately due and payable.

Worker's Compensation – If our office has received your claim information and authorization, no payment is necessary at the time of the visit. If claim information and/or authorization has not been received, payment in full is to be collected at the time of service.

Third Party Liability – Our office does not bill auto insurance or homeowner's claims. You are expected to pay for services in full at time of service. Please check with all your insurance policies to see who will cover your treatment.

FINANCIAL POLICY

ADDITIONAL CHARGES

NON-COVERED SERVICES AND/OR DURABLE MEDICAL EQUIPMENT/SUPPLIES (DME):
As part of your treatment, your physician may provide services, such as medications or durable medical equipment:

- ✓ Medications- *Lidocaine, Marcaine*
- ✓ Durable Medical Equipment - *TheraBand, Ace Bandages, Elbow Sleeves, Splints, Coban, Braces, Slings or Gortex Liner, etc.*

Your physician may determine that it is important to your treatment plan that you be shown how to use the durable medical supplies you have received today. This office will bill your insurance; however, any non-covered supplies will be your financial responsibility.

______ (Initials)

Please be advised that the durable medical supplies listed above are available for purchase at most major drug stores and medical supply companies. You may opt to purchase your supplies from those retailers.

DISABILITY FORMS: Our office charges $25 for each disability form that you ask Southwest Shoulder Elbow & Hand Center, PC to complete. The disability form may be for your employer, home or auto loan, or any other facility that requires disability information on your behalf. Allow up to five business days to process your request.
MEDICAL RECORDS: A copy of records for the patient or for another treating physician is provided without charge. Copies for Attorneys and other legal matters are subject to applicable fees.
NSF: We charge a $40.00 NSF fee for any returned checks.
COLLECTIONS: In the event that outside collection and/or legal costs are incurred by this office to obtain payment due, responsible party agrees to pay all cost of collection, including attorney fees, collection fees, and contingent fees to collection agencies which may be more than 35% of the delinquent balance, such contingency fee to be added by the provider and collected by the collection agency immediately upon our referral of your account to the collection agency of our choice.
NO SHOW or CANCELLATIONS: Cancellations with less than 24-hour notice or No Shows will be assessed a $25 fee.

ACKNOWLEDGEMENT: *I have read, understand, and agree to the above Payment Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments, co-insurance, and deductibles, are my responsibility and due at the time of service. Any unpaid balances may be subject to a finance charge or above stated collection fees.*

I authorize SOUTHWEST SHOULDER ELBOW & HAND CENTER, P.C. to release pertinent medical information to my insurance company when requested or to facilitate direct payment of a claim.

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Signature of Patient or Guardian Name of Patient

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(print) ***Date***

SW Hand Representative (initials) ______________

Revised April 2024