FINANCIAL POLICY AND CONSENT FOR TREATMENT

Thank you for choosing us as your Orthopedic Health Care Provider. The following is our Financial Policy and Consent for Treatment. Our main concern is that you receive the proper optimal treatments needed to restore your health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to contact our billing office.

All patients (guardian of minor) must present a picture ID and all insurance information prior to being seen in our clinics.

CONSENT FOR TREATMENT: I am presenting myself for outpatient care at Allied Orthopaedics/Direct Orthopedic Care and I voluntarily consent to rendering of such care, including diagnostic procedures and medical treatment by authorized agents, employees of Allied Orthopaedics/Direct Orthopedic Care and the medical staff (or the designees) as in their professional judgment may deem necessary. I acknowledge that no guarantee has been made to me as to the result of examination or treatment in this clinic.

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Allied Orthopaedics/Direct Orthopedic Care of all insurance benefits, to which I would otherwise be entitled for these services. I understand that I will be obligated to pay for any service not paid for by my insurance including (but not limited to) services that are deemed to be medically necessary. I accept financial responsibility to Allied Orthopaedics/Direct Orthopedic Care for 100% of the charges. I will pay any legal fees incurred by Allied Orthopaedics/Direct Orthopedic Care in collecting this account.

SURGICAL DOWN PAYMENT: For all commercial insured patients a $500 down payment is required prior to any surgical procedures.

SURGICAL ASSIST: The Allied Orthopaedics physicians may utilize a surgical assistant during surgery. If so, you and/or your insurance company will receive a separate bill for this service.

REFERRALS: You are responsible for providing a referral from your primary care physician as required by and consistent with the requirements of your insurance plan. If a referral is not available, you will have to come back or reschedule once its obtained.

INSURED PATIENTS: Insurance cards and/or insurance forms must be presented prior to being seen. All co-pays and deductibles are due at the time services are rendered, NO EXCEPTIONS. All insured patients are required to sign the assignment of benefits of for payments made by the insurance company.

CASH PATIENTS: Payment for services is due at the time services are rendered. For all uninsured patients, a new patient initial visit or an established patient new injury visit to Allied Orthopaedics/Direct Orthopedic Care will be a $400 charge due at the time of visit. All subsequent visits will be a $200 charge paid at the time of service. Uninsured patients receiving Viscosupplementation injections will have an additional $600 charge for the medication. This payment is in addition to our standard self-pay policy and is due at the time of service. For all uninsured patients coming in for a concussion visit the charge is $200 due at the time of visit and all subsequent visits will be a $100 charge due at the time of visit if following up for the same injury. Charge is due at the time of visit, NO EXCEPTIONS. If patient is surgical please refer to surgical consent form. We accept cash, check, Mastercard or Visa. If you are not able to make payment at the time of service, please reschedule for when you are able to do so.

WORKERS COMPENSATION: In the event it is determined by the Worker's Compensation board that the injury is not a result of compensable Worker's Compensation case, we will bill any private insurance. The balance is your responsibility.

DISCLOSURE: Allied Orthopaedics/Direct Orthopedic Care physicians share financial interest in Treasure Valley Hospital and Sawtooth Physical Therapy.

FEES FOR RETURNED CHECKS: Returned checks will be subject to a $25 fee, for processing.

CANCELLATIONS: Please contact our office within reasonable time to cancel your appointment, preferably 24 hours' notice.

NO SHOW's: If you do not show for a scheduled appointment you will be subject to a $25 fee per missed appointment.

*****Any unpaid balances will be assessed a 25% APR late fee after 60 days. *****

THIS FORM HAS BEEN FULLY EXPLAINED TO ME AND I CERTIFY THAT I HAVE READ IT, UNDERSTAND ITS CONTENTS, AND VOLUNTARILY AGREE TO ITS PROVISIONS AND HEREBY CONSENT TO ALLIED ORTHOPAEDICS/DIRECT ORTHOPEDIC CARE.

Patient Name (PLEASE PRINT):_____ **Date of Birth:** _____

Patient/Legal Guardian Signature:_____ **Date:** _____

Witness Signature (Clinic Staff):_____ **Date:** _____