



**ACKNOWLEDGEMENT OF PAYMENT RESPONSIBILITY**

I have read and understand the *Financial Policy* of West Michigan Orthopaedics and agree to its terms. I understand that I am financially responsible for any services and/or materials provided by West Michigan Orthopaedics, including items denied or not covered by my insurance and any yearly deductible or co-payment amounts. I agree to pay all services within 30 days unless a payment plan is negotiated in advance.

**SIGNATURE:** \_\_\_\_\_  
(Patient, Personal Representative or Parent/Guardian if minor)

**DATE:** \_\_\_\_\_

**AUTHORIZATION TO ASSIGN MEDICAL BENEFITS**

I hereby authorize my insurance benefits to be paid directly to West Michigan Orthopaedics. This release shall remain in effect until revoked by me in writing. A photocopy of this release shall constitute a valid authorization.

**SIGNATURE:** \_\_\_\_\_  
(Patient, Personal Representative or Parent/Guardian if minor)

**DATE:** \_\_\_\_\_

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I understand that West Michigan Orthopaedics may use or disclose my protected health information for treatment, payment or healthcare operation purposes as described in the Notice of Privacy Practices and to the extent permitted by law. I understand this may include, if applicable, information relating to AIDS, HIV, psychiatric care, alcohol abuse and/or drug abuse.

**SIGNATURE:** \_\_\_\_\_  
(Patient, Personal Representative or Parent/Guardian if minor)

**DATE:** \_\_\_\_\_

**PLEASE READ THIS FORM CAREFULLY BEFORE SIGNING ABOVE.**

**INSURANCE INFORMATION**

*Please provide us with complete insurance information and bring all insurance cards with you to your appointment. We will then submit the claim to your insurance company on your behalf. We extend 30 days for your insurance to respond and then the charges become your responsibility to pay. Please note that your insurance policy is a contract between you and your insurance company; therefore, it is your responsibility to know and understand your insurance plan and the contractual obligations associated with it.*

**● MEDICARE**

We are participating providers with the Medicare program, including original Medicare and the Medicare Advantage plans such as Medicare Plus Blue, Humana Choice, Priority Medicare, Secure Horizons and UniCare Security. We will submit all claims on your behalf and Medicare will send payment directly to us. We will only bill you for items not covered by Medicare, your yearly deductible, and/or your co-payment amounts. If you have supplemental insurance, we will submit the claim for their consideration after Medicare responds.

## **INSURANCE INFORMATION CONTINUED –**

### **● HMO, PPO AND OTHER NETWORKS**

We are specialty providers for Aetna, ASR Physicians Care, Blue Cross Blue Shield of Michigan Traditional, Blue Cross Blue Shield of Michigan PPO, Blue Care Network, CIGNA, Grand Valley Health Plan, PPOM, Priority Health and United Healthcare. If you have questions about our participation in other programs, please ask prior to your appointment as benefits may be affected. If your insurance plan requires a referral from a primary care physician, it is your responsibility to contact that physician for preauthorization before each appointment. All co-payments are expected at the time of your appointment.

### **● SELF-PAY / NO INSURANCE**

Payment is expected at the time of your appointment. If you are unable to pay your balance in full, please contact our office prior to your appointment to negotiate a payment plan.

### **● WORKER'S COMPENSATION**

For a work-related injury or condition, we require authorization from your employer's insurance carrier prior to your appointment. The authorization must include the name and address of the insurance company, the date of injury, the nature of the injury or condition, the claim number, and a carrier personnel signature. We will then bill all services directly to the carrier.

### **● AUTOMOBILE INSURANCE**

For an automobile-related injury or condition, we must have the name and address of your insurance carrier, your claim representative's name, the claim number, and the date of the accident. It is also important that you let us know whether your automobile insurance is primary or secondary. Because we do not maintain a participating contract with any automobile insurer, payment is expected within 30 days in the event a balance remains.

## **METHOD OF PAYMENT**

We accept payment by cash, check, Visa, MasterCard and Discover.

## **SOCIAL SECURITY NUMBERS**

We take the responsibility of safeguarding your personal information very seriously. Your social security number will be kept strictly confidential in accordance with federal (HIPAA) and state (Michigan Social Security Number Privacy Act) regulations. Your social security number is not required to obtain medical services, but a credit card will be necessary to secure those services if one is not provided.

## **RETURNED CHECKS**

Returned checks will be re-deposited automatically and without notice. A \$20.00 processing fee may be charged for checks returned by the bank for non-sufficient funds (NSF checks) regardless of the amount of the check. When a check is returned, West Michigan Orthopaedics reserves the right to require payment by cash or certified funds.

## **NON-PAYMENT OF ACCOUNT**

Failure to pay your balance in a timely manner may result in a referral to a collection agency. In addition to the effect collection action will have on your credit rating, future services provided by West Michigan Orthopaedics may be jeopardized.

## **MEDICAL RECORDS**

We will respond to requests for copies of medical records in a timely manner. In some instances, there is a fee for this service, which will be quoted at the time of the request.