North Alabama Bone and Joint Clinic, P.C.
Patient Financial Policy

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, or your financial responsibility. If you need further assistance, contact our patient account representative: Donna McCainey, 256-718-3200 ext. 235.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL ASK TO SEE YOUR INSURANCE CARD ON EVERY VISIT AND WILL SCAN YOUR CARD INTO OUR SYSTEM AS NEEDED TO KEEP OUR INFORMATION CURRENT.

MINOR PATIENTS: Parents are financially responsible for care rendered to their minor child(ren). The adult (parent/guardian) accompanying the minor to the first visit is responsible for any balances not covered by the insurance plan. Minors not accompanied by an adult will be rescheduled if the appointment is non-emergent. If the parent gives written permission to treat without a parent present and the charges have been pre-authorized for payment prior to treatment, then the minor can be treated.

COPAYMENTS: Your insurance REQUIRES that we collect your designated co-pay at the time of service. Please be prepared to pay the co-pay at each visit.

SELF-PAY: Self-pay accounts shall exist if a patient has no insurance coverage. For new patients, a payment of $250.00 is expected on the day of your appointment before being seen by the health care provider. If you are unable to pay the $250.00, please contact our patient account representative prior to your appointment.

EXTENDED PAYMENT PLANS: Patients are encouraged to pay outstanding self-pay balances in full. However, payment plans may be accepted with the approval of the business office extending payments over a (6) six-month period. If you are unable to pay within (6) six months, arrangements with our patient accounts representative must be made.

REFERRALS: If your plan requires a referral from your primary care physician it is your responsibility to obtain it prior to your appointment and to have it with you at the time of the appointment. IF YOU DO NOT HAVE YOUR REFERRAL, YOU MAY BE REQUIRED TO RESCHEDULE.

ACCIDENT/WORKERS COMP CASES: Patients shall be financially responsible for medical services related to accident/workers comp. It is the responsibility of the patient to notify North Alabama Bone & Joint Clinic, P.C. of: date of injury, claim #, insurance company address, phone #, and contact person prior to first treatment for the injury.

MEDICARE: We will submit to Medicare for the Medicare allowed amount. The patient will be responsible for the deductible and the co-insurance, which can be billed to a secondary insurance if you have one.

RETURNED CHECK FEES: Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being assessed a fee of $30.00 per check returned. We reserve the right to require future payments to be made by credit card, money order or cash.

AGREEMENT TO PAY & ACCEPTANCE OF PAYMENT POLICY: I, the undersigned, accept the fee(s) charged are due at the time of service. Should it become necessary to forward my account for collection, I agree to pay all monies due, including a 33.33% collection fee, Attorney fees, and/or Court Costs, if such be necessary. I waive now and forever, my right of exemption under the laws of the Constitution of the State of Alabama and any other state. I, the undersigned, give North Alabama Bone and Joint, its employees and agents, express

prior consent to contact me at any/all phone numbers, including cell phone numbers, for the purpose of treatment, insurance and/or payment.

**AUTHORIZATION FOR SERVICES: The signature below serves as authorization for services rendered by North Alabama Bone & Joint Clinic, P.C. for the above-named patient, and release of information necessary to file insurance; and assign benefits otherwise payable to policy holder to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by the insurance carrier- a copy of the signature is as valid as the original.

**AUTHORIZATION FOR RELEASE OF INFORMATION: The signature below serves as authorization for Rehab and Sports Medicine of the Shoals, Inc. to release or receive medical information for the purpose of patient referral. A copy of this signature is as valid as the original.

I have read this Financial Policy and agree to its terms.

Responsible Party Signature: _____ Date: _____

Patient Name: _____

Acct. #_____

(FOR OFFICE USE ONLY)