ATTENTION

WE MAY ***NOT*** BE CONTRACTED WITH YOUR INSURANCE.

If you do not meet the **EMERGENCY ROOM REFERRAL** or **90 DAY GLOBAL PERIOD** descriptions below:

NEW PATIENTS will be required to pay a **$200.00** deposit for your visit.

ESTABLISHED PATIENTS will be required to pay a **$75.00** deposit for your visit.

EMERGENCY ROOM REFERRAL: If you have been referred to our office from the emergency room, generally your insurance will authorize your initial visit with us, ***but no subsequent visits.*** It is important that you check with your insurance company regarding your benefits. Some insurance companies offer out-of-network benefits. If so, your insurance will pay at the reduced benefit and ***you will be responsible for the remaining balance***.

90 DAY GLOBAL PERIOD: If you were seen and treated in the emergency room by one of our surgeons and the treatment/procedure you received has a 90 Day Global Period all visits within the 90 Day Global Period are included in the surgical package. After the 90 days you will be required to pay a deposit for your visit. If you do not have out-of-network benefits or you choose to not utilize your out-of-network benefits, our office staff will assist you in finding a contracted provider.

TREATMENT AGREEMENTS:

1. Your treatment is our top priority. If we dedicate our time to your care, it is our expectation that you are compliant in your follow-up visits until completion.
2. We schedule appointments for our convenience AND yours. When you are late for your appointment, it affects all other patients scheduled for that day. Therefore, for those who are more than 10 minutes late, we will do our best to fit you into the schedule as quickly as possible without delaying others. Please call 24 hours in advance for cancellations. We politely remind you that we are a trauma service and emergencies do arise.
3. We feel we offer you the best professional care, skill, judgment in planning and delivery of treatment for your orthopedic injuries. Your payment is reimbursement for our services. **By signing below, you are agreeing to fulfill your financial commitment to our office promptly and completely, and you further agree to pay for all collection costs, attorney fees, and other costs that may be incurred to enforce collection of any amounts outstanding.**

4. **Blue Cross Blue Shield Patients: Should you receive a check from your insurance company, DO NOT SPEND IT!** Insurance companies commonly send your surgeons compensation to the patient since we are non-contracted with them. If you receive a check from the insurance company for our services, please contact our office. ***If your insurance company notifies us that your surgeon's payment was sent to you, you will be expected to pay your balance in full immediately.***

Please remember that insurance is considered a method for reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Any unpaid debt to our office is your responsibility.

I, _____ have read the above and understand my responsibility in knowing my benefits and what will be my financial responsibility.

_____ _____

Signature Date