

NEW HOPE ORTHOPAEDICS & SPORTS MEDICINE FINANCIAL POLICY

PATIENT NAME _____ DATE _____

Payment is due at time of service. We accept MASTERCARD, VISA, CASH OR MONEY ORDERS.

As a courtesy to you, we will file your medical services with your insurance carrier. We strongly encourage you to contact your insurance company within 30 days if you have not received an explanation of benefits.

- Patients are responsible for co-payments, deductibles, non-covered services or supplies at the time services are rendered. Any unpaid balance after 60 days is your responsibility.
 1. I understand that it is my responsibility to know what my insurance requirements are.
 2. I understand that it is my responsibility to provide New Hope Orthopaedics & Sports Medicine with the following if required by my insurance company.
 - A. Referral from Primary Care Physician.
 - B. Paperwork required by your insurance that needs to be attached to any claim we file on your behalf.
 3. I understand that I am liable for any services denied by my insurance carrier for any of the reasons listed in number (2) above. I understand that I am also responsible for all charges not covered by my insurance carrier.
 4. If insurance benefits are mailed to me, I agree to forward them directly to NEW HOPE ORTHOPAEDICS & SPORTS MEDICINE along with any explanations of benefits.
 5. If payment is not made after reasonable notice of any balance due on my account, I will be responsible for all collections effort fees including attorney and court costs.
- Self-pay patients are required to bring \$200.00 for the first office visit; charges may vary, depending upon service rendered (such as x rays). Payment plans are sometimes made for additional charges.
- We do not accept third party insurance. Therefore, if your medical condition is a direct result of a motor vehicle accident, you will be listed as a self-pay patient and payment will be required.
- There will be a \$30.00 charge for any returned checks and a \$25.00 charge for not showing for your schedule appointment. We ask you give 24 hour notice when canceling.
- Insurance and disability forms are \$10.00 per form. After receiving your forms they will be completed in approximately 5-7 business days. Your portion must be completed and signed prior to the completion of the form. All envelopes must be stamped and addressed to ensure proper delivery. Your payment is expected before forms can be mailed or faxed, there are no exceptions. New Hope Orthopaedics & Sports Medicine is happy to offer you this service, however please remember it is your responsibility to get your paperwork to us. Please do not expect us to expedite your forms.
- Copies of X-rays can be obtained for a fee of \$5.00 per sheet.

Signature of Patient or Parent/Guardian

Date signed

FINANCIAL INTEREST DISCLOSURE

The Physicians of New Hope Orthopaedics & Sports Medicine have a financial interest in the Riverview Surgery Center and the Carmel Ambulatory Surgery Center. As a patient of New Hope Orthopaedics & Sports Medicine, you may be referred to these facilities to receive medical services. You may however, choose to be referred to another health care facility to receive these services.

I acknowledge and understand my patient rights pursuant to Indiana Law HB 1306 witness it below with my signature.

Print Patient Name _____ Date of Birth _____

Signature _____ Date _____