

## **Financial Policy**

Commonwealth Orthopaedics & Rehabilitation, P.C. appreciates the confidence you have shown in choosing us for your health care needs. We are fully committed to providing you with the highest level of service and quality of care. We appreciate the opportunity to serve you and welcome feedback to improve your patient experience.

We accept most insurance plans and will gladly file insurance claims on your behalf. Ultimately you hold the financial responsibility for your account.

We ask that you remit any applicable copay and deductible according to the terms of your insurance contract at the time services are rendered. Furthermore, if you do not pay your copay at the time of your appointment, we retain the right to levy an administrative charge of \$20 to your account in order to defray the cost of billing and collecting the copay at a later time. Additionally, it is your responsibility to provide any necessary referral information to us that your insurance requires prior to your visit. We also ask that you notify us of any changes to your insurance information prior to each visit.

If you do have an outstanding balance due, we appreciate prompt payment in full. If you are unable to make payment in full, please inquire about arranging a payment plan. If multiple attempts to collect payment from you are unsuccessful, we reserve the right to turn the outstanding balance due to a collection agency. In addition to the principal balance due, you will also be responsible for any interest accrued plus any legal or collection agency fees incurred.

Any payment made to us in the form of a check that is returned for insufficient funds will incur a \$25 fee per incidence.

## **Office Policy**

We place a high value on your time and will make every attempt to ensure a positive experience. We will do our best to adhere to our scheduled appointment time. If you are unable to keep your scheduled appointment, please notify us at least 24 hours in advance. If you fail to provide us with a 24 hour notice of cancellation or fail to keep your scheduled appointment, we reserve the right to charge you a \$30 no show fee.

## **Physical Therapy Policy**

If you are unable to keep a physical therapy appointment, please notify us at least 24 hours in advance. If you must cancel your previously scheduled appointment and do not provide the required notice, you will be charged a \$30 cancellation fee. Additionally, if you are unable to keep your scheduled appointment and do not notify us, you will be charged a \$50 no show fee. Finally, if you schedule an initial evaluation appointment and fail to keep the appointment, you will be charged a \$130 fee.

## **Surgery Policy**

If you are unable to keep a scheduled surgery appointment, please notify us at least 7 (seven) days in advance. If you fail to provide us with adequate notice of cancellation or fail to keep your scheduled surgery, we reserve the right to charge you a \$250 fee.

If you have surgery performed in one of Commonwealth's outpatient surgery centers, you likely will receive three separate charges for the services provided: one for the surgeon's fee, one for the facility, and one for the anesthesiologist.

If you have surgery in an outside facility (a hospital or non-Commonwealth surgery center), you will receive a bill from us representing the surgeon's fee. In addition, you likely will receive separate bills for services rendered by the facility, anesthesiology, and possibly radiology and pathology. Please be sure that you understand your insurance coverage and benefits prior to undergoing surgery.

## **Durable Medical Equipment**

There may be occasions when your course of treatment requires the use of an orthopaedic appliance or soft good to facilitate your rehabilitation. In these instances, we will verify your benefits and file a claim to your insurance company when applicable. In cases where insurance does not cover the required equipment we do require payment in full for the equipment at the time of service.

## **Consent**

My signature below indicates my full understanding and consent to the above described policies. Additionally, I provide authorization to my insurance company to pay any applicable benefits directly to Commonwealth Orthopaedics & Rehabilitation, P.C.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guarantor signature (if guarantor is not patient)

\_\_\_\_\_  
Date

