PATIENT FINANCIAL POLICY

Thank you for selecting the **Long Island Orthotics & Prosthetics** for your orthotic & prosthetic care. In order to prevent any misunderstanding concerning the responsibility regarding payment for any orthotic or prosthetic fees, the following information is provided:

Insurance Card(s) and Drivers License:

We require a copy of your insurance card and driver's license or photo id for our records.

Insurance

❖ HMO / PPO / Other Insurance Coverage

It is your responsibility to know and understand your insurance coverage and the requirements for prior authorization, care notification and the billing of orthotics, prosthetics or durable medical equipment as specified under your policy. If you have coverage with a plan that we do not have a prior agreement with, we will prepare and send the claim for you. **All deductible or copayments are due upon delivery of the device(s) provided, unless otherwise advised.** Failure to provide all necessary information may require you to pay in full for your device. **You will be responsible for the denial of any device(s) or service(s) by your insurance carrier that are deemed not medically necessary and/or not covered.**

❖ Medicare

Our facility is participating with Medicare and ***accepts*** Medicare assignment, which is the ALLOWABLE charge approved by Medicare. Medicare will pay 80% of the allowable charges after you pay for your annual part B deductible. You are responsible for any amounts applied to your deductible and the 20% coinsurance. If you have other insurance, we will submit as a courtesy (please refer to the paragraph above regarding any insurance billed other than Medicare or Medicaid).

❖ Medicaid

Our facility is participating in the Medicaid program and ***accepts*** Medicaid assignment. It is your responsibility to know whether you are actively covered by Medicaid on the date your device(s) are delivered or service(s) are rendered. **You will be responsible for any services denied by Medicaid if your insurance coverage was not active on said date(s).**

❖ Self Pay Patients

For patients with no insurance, the guarantor is responsible for the bill at the time of service.

Minors

For all services rendered to minor patients, we will hold the parent or guardian accompanying the minor responsible for expenses incurred.

Payments

Payments can be made by cash, check, VISA, MasterCard, American Express and Discover.

Balances Due

Patient balances are due within 30 days of receipt of statement. There will be a 2% additional charge on any outstanding balance or a $3.00 minimum additional charge on any outstanding balance if payment is not received in thirty (30) days unless previous arrangements have been made in advance with our Billing Office.

Returned Checks and Collections

A charge of $20 will be made for all returned checks. In the event that any action is brought to collection, I agree to pay any reasonable collection costs and/or attorney fees.

YOUR SIGNATURE ON PAGE ONE ACKNOWLEDGES REVIEWING AND ACCEPTING THESE TERMS.

PATIENT FINANCIAL POLICY (continued)

Benefits Assignment

I hereby authorize the assignment of benefits (payments) directly to **Long Island Orthotics & Prosthetics** for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-pays, deductibles and non-covered services are due at the time of service.

YOUR SIGNATURE ON PAGE ONE ACKNOWLEDGES REVIEWING AND ACCEPTING THESE TERMS.

Records Release

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

YOUR SIGNATURE ON PAGE ONE ACKNOWLEDGES REVIEWING AND ACCEPTING THESE TERMS.

GUARANTEE OF PAYMENT

- Provider Name: **Long Island Orthotics & Prosthetics**

I have read and understand the information above. I understand that my insurance company may deny coverage and request that **Long Island Orthotics & Prosthetics** perform this medical service anyway. I agree to be personally and fully responsible for all charges. I understand that the provider named above is relying on this promise and may be rendering services without requiring payment at the time of service based on such reliance.

YOUR SIGNATURE ON PAGE ONE ACKNOWLEDGES REVIEWING AND ACCEPTING THESE TERMS.

WARRANTY POLICY

At Long Island Orthotics & Prosthetics our warranty covers defects in materials and workmanship for ***thirty days on soft goods and ninety days for all other products*** following the date of delivery. We will repair or replace any defective part(s) of the device at no charge during the warranty period. ***Orthotic & Prosthetic devices are not returnable or refundable once worn outside the office.*** Replacement parts may differ from the original product due to upgrades or changes in device design and technology.

This warranty includes adjustments that are not due to anatomical changes, i.e. loss or gain of weight and realignment.

This warranty will not apply if misuse, accident, alteration, neglect, unauthorized repair, or improper care has damaged the device. Only our facility is authorized to adjust, modify or repair the device or the warranty will be voided. Linings, straps or wear and tear items are not covered under warranty.

Additionally, damage caused by normal wear and tear of the device is not covered. Manufacturer's warranty may apply to certain components. Certain manufacturer's warranty extends beyond ours; however, charges for shipping, handling, and labor apply.

Note: We reserve the right to use existing technology at time of parts replacement/repair, if appropriate.

I understand and agree to the terms of **Long Island Orthotics and Prosthetics** Warranty Policy.

YOUR SIGNATURE ON PAGE ONE ACKNOWLEDGES REVIEWING AND ACCEPTING THESE TERMS.