Our 2017 Financial Policy

Regarding Insurance: You must show us your insurance card. For Medicare patients, this includes both your Medicare card and your card for any other health insurance, such as supplementary coverage, that you have. If you received a new card, you must provide it to us. If your insurance has lapsed or is not in effect at the time of service, you will be required to pay the entire bill for services provided when it has lapsed or is not in effect.

About non-covered services: Some of our services are considered by insurers to be "non-medically necessary procedures". Insurers will not pay for "non-medically necessary procedures". You will be required to pay in full for these procedures at the time of services unless other arrangements are made with our office manager at the time that the appointment is made.

If we have a contract with your insurance plan:
If you have an HMO, PPO or POS insurance plan with which we have a contract, and if your card says that you have a co pay, you must pay that co pay before you will be seen for your appointment.
If your insurance company tells us that you have not satisfied your deductible for the year, then we will bill you for the deductible amount that you are required to pay, and you must pay us. If payment is not received within 30 days, we reserve the right to add a finance charge of 1.5% per month to your open balance.

If we DO NOT have a contract with your insurance plan:
You will be required to pay in full for the procedure at the time of the service unless other arrangements are made with our office manager at the time of the appointment.
We will bill your insurance plan unless you ask us not to do so, and will instruct the plan to make payment to you (because you have already paid us). If you do not agree with your plan's payment, that is between you and your plan, because we do not have a contract with your plan.

If the insurance payment comes directly to you (assuming we have haven't gotten paid) we expect to have the full payment forwarded to Swiss Orthopedic immediately.

If you are not sure whether we have a contract with your insurance plan, please discuss this with our staff.

Medicare patients:
You must give us your Medicare card and the card for your supplemental or other insurance.
You will be required to satisfy your annual $183.00 deductible and pay your 20% co-insurance. We do not require that you pay us at the time of service, and we will submit the claim to Medicare and to any secondary or supplemental insurance that you have, if we have all the cards on file.
Sixty days after the appointment, we will bill you for the balance, if it applies.
If payment is not received with 30 days, we reserve the right to add a finance charge of 1.5% per month to your open balance.
By signing below, you acknowledge receiving a copy of Swiss Orthopedic Co., Inc.'s Notice of Privacy Practices and Financial Policy.

Minor Patients of Divorced Parents: A divorce decree is a legal decree binding only the parties to the decree.
If we are contracted with the insurance plan that covers the minor, payment of the co pay is due before the service is provided. We will then submit the claim to the insurance carrier. The parent who is responsible for paying the medical bills will be responsible for payment of any balance due after the insurance carrier makes its payment.
If we are not contracted with the insurance that covers the minor, deposit at the first visit is required and balance due at the time of the pickup. We will submit the claim to the insurance (unless the primary on the policy asks us not to), and the payment will go directly to the primary on the policy.

Release of medical information and assignment of benefits. You authorize the release of medical information necessary for filing health insurance claims by Swiss Orthopedic Co., Inc. You also authorize your insurance carrier(s) to make payment(s) directly to Swiss Orthopedic Co., Inc.

Thank you for your understanding of our financial policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy (above). I understand and agree to this Financial Policy.

______________________________ ________________________
Signature of Patient or Responsible Party   Print Name of Patient

______________________________ ____________________
Relationship/Authority of Responsible Party   Date