Date _____ Provider _____ Patient _____

Lancaster Orthopedic Group-Financial Policy

- I understand that payment for services is due at the time services are rendered. Any outstanding balances are due within 30 days, unless prior arrangements have been made with the Business Office. All balances that reach 90 days or older may be sent to a collection agency. **All accounts sent to a collection agency will be charged an additional 18% collection fee**.
- **Patient responsibility costs**: We will gladly try to answer any questions related to your insurance, but because insurance plans are so varied, we cannot tell you what your costs will be for procedures and tests. Your insurance plan determines what part is your responsibility in a unique manner. Because of the dynamic nature of co-pays, deductibles, and co-insurance, we are unable to accurately give you an answer about what your responsibilities will be as they are determined by your insurance carrier at the time your claim is processed. Your insurance card will sometimes alert us to co-pays, but not all co-pays. Your insurance is a contract between you, your employer (possibly), and the insurance company. Your individual plan determines your coverage, any requirements for prior authorizations or referrals and establishes the limits on your coverage for medical services. We are not a party to that contract except where we are contracted as preferred providers.
- If we do participate with your insurance company, all services performed in our office and at the hospital will be submitted to your insurance. All co-pays and deductibles are your responsibility and are due at the time services are rendered.
- If we do not participate with your insurance company, we will bill your insurance carrier as a courtesy to you. We do not accept payment from them as payment in full for services performed. Any balances not covered by the insurance company become your responsibility.
- Fracture care, whether operative or non-operative is considered a major surgical procedure. Medical billing for all major surgical procedures generally involves a set fee for the procedure and follow up visits for a period of 90 days following treatment. This is commonly referred to as a "Global Surgical Package" and **does not** include the initial consultation or evaluation by the surgeon to determine the need for major surgery; visits unrelated to the diagnosis for which the surgical procedure is performed; diagnostic tests and procedures including x-rays; treatment for post-op complications that require a trip to the operating room; additional cast applications and supplies; any braces or splints that may be required; and a more extensive procedure if the less extensive procedure fails.
- We must emphasize that as an orthopedic practice, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from the date services are rendered. **Therefore, it is often necessary for you to inquire and explore your benefits with your insurance carrier**. We realize that temporary financial problems may affect timely payment of your account and if such problems do arise, we encourage you to contact our business office for assistance in the management of your account.
- **Some of our physicians are part owners of various Outpatient Surgery Centers to which we may refer you for a procedure. You will always have the option to choose another location at which that physician performs that procedure.**
- I have read and fully understand the financial policy set forth by Lancaster Orthopedic Group and I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby assign all medical benefits to which I am entitled, including Medicare, Private Insurance and any other health plan to Lancaster Orthopedic Group. This assignment is to be considered as valid as the original.

_____ _____

Date **Signature of Patient or Authorized Representative**

Consent for Treatment

- I do hereby voluntarily consent or permit any associated physician or assistant of Lancaster Orthopedic Group Inc. of Lancaster, PA to perform diagnostic procedures, and such medical/surgical procedures as necessary or advisable in their judgment for my medical care.

_____ _____

Date **Signature of Patient or Authorized Representative**

Consent for Medical Student Observation

- From time to time we have medical students and physician assistant students shadowing a physician as part of their program requirements. You are consenting to this process.

_____ _____

Date **Signature of Patient or Authorized Representative**

Consent for Release of Information

- I authorize release of any medical information concerning my treatment to my insurance company, family physician, referring physician, primary care physician, any physician in the course of care for this issue, any treating facility, my employer or rehab nurse in the case of workers' compensation, or the following persons:

  [ ] Spouse [ ] Children [ ] Parents, if over 18 [ ] Sports Trainer/Coach [ ] Other family member(s)

  Name(s): _____

- Please specify an Emergency Contact:

  Name: _____ Phone: _____

The life of this Consent for Release of Information form is one year (12 months) from the date you sign unless a new consent is signed.

_____ _____

Date **Signature of Patient or Authorized Representative**

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