

**PAYMENT POLICY, FINANCIAL AGREEMENT
AND PRE-AUTHORIZATION POLICY**

- Payment for services and supplies are due at the time services are rendered. (Unless previous arrangements have been approved in advance).
- We accept checks, Visa and Mastercard. (Returned checks are subject to additional service charges).
- When we are a participating provider with your insurance company, your referral form, co-pay, coinsurance or deductible is due at the time of service. If payment is not made upon checking out of the office, an administrative fee of \$20.00 will be applied to your account.
- If the patient fails to make payment, or the account is placed in collection, the patient will be responsible for collection costs, attorney fees and a monthly interest charge of 1.5%.
- The patient will be responsible for any denied services or service not covered by insurance.
- In the case of a motor vehicle accident, a claim may be billed with your motor vehicle carrier for payment to the Orthopedic Institute of New Jersey.
- Surgical procedures may require deposit, including deductible and or co-pay. Remaining balances are to be paid within one month of settlement with your insurance company. We will pre-approve the surgical procedure with individual insurance carriers to determine benefits. However, it is ultimately the patient's responsibility to pre-approve all procedures and to be aware of your insurance guidelines.
- Pre-certification is not a guarantee of eligibility or benefits. Your claim will be considered for payment after it has been received and reviewed by your insurance company.
- Most insurance plans require pre-authorization for diagnostic services such as MRI's and CAT scans, etc. The office requires 48-72 hours to initiate such services. Please do not obtain such tests without proper authorization or you will be responsible for charges.

I am in agreement with Payment Policy and Financial Agreement and Pre-Authorization Policy stated above. I agree and certify that a photocopy of this document will be acceptable as the original.

I hereby authorize the release of any medical information necessary to process the direct payment of medical benefits to the named provider.

My medical records are the property of Orthopedic Institute of New Jersey, LLC and require signed permission prior to their release to anyone other than Orthopedic Institute of New Jersey, except for the release of information to another treating physician or specialist.

My signature indicates that I have read, understand and agree with the above statements.

Patient/Parent Signature _____

Date: _____