FINANCIAL POLICY

Thank you for choosing Seven Springs Orthopedics as your Orthopedic specialty healthcare providers. We are committed to providing you with the best available medical care. In our ongoing process to make sure all of your medical needs are met, our staff will be available to discuss our fees and this policy with you. The services you have elected to participate in imply a financial responsibility on you part.

Payments for all services will be due at the time services are rendered. In order to better serve you, we accept cash, check, Visa, MasterCard, Discover, and American Express. As a courtesy to you, we will verify your coverage and bill your insurance carrier on your behalf; however, you are ultimately responsible for the entire bill. As the responsible party, please understand:

- Your insurance policy is a contract between you, your employer (if applicable) and your insurance provider. Seven Springs Ortho is a party to that contract. Our relationship is with you, not your insurance provider. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance or "usual and customary" charges. As your medical provider, we will only supply factual information to facilitate claims processing.
- I understand that I may have an insurance plan that restricts my therapy either by units or by payable dollar amount and that it is my financial responsibility for the difference between services covered by my policy and the actual services provided.
- Fees for services, which include unpaid balances, deductibles, co-payments, and coinsurance, are due at the time of service. I understand should I receive treatment, a co-pay will be due at the time of service for each visit. I understand and agree if I fail to make payments for which I am responsible for within three statement billing cycles, after such default and upon referral to a collection agency or attorney by Seven Springs Ortho, I will be responsible for all costs or collecting monies owed including collection agency fees.
- All charges are my responsibility. If my insurance carrier does not remit payment within sixty days, the balance may be due in full from me. If any payment is made directly to me for services billed by Seven Springs Ortho, I recognize an obligation to promptly remit payment to Seven Springs Ortho.
- I understand should I incur a balance that I am unable to pay within three billing cycles; I am required to contact Seven Springs Ortho to set up a payment plan.
- Completion of disability and/or FMLA forms are not billable/reimbursable by insurance carriers, therefore, fees are my responsibility for payment. Seven Springs Ortho fees related to completion of these documents are expected to be paid upon presentation of forms for completion.
- Returned checks and unpaid balances may be subject to collection placement and a collection fee for first placement. If legal action is required, I will be responsible for all costs of collecting monies owed including processing fees.
- Seven Springs Ortho utilizes the services of Surgeons/Physician Assistants/Nurse Practitioners for all medical services, including surgical procedures. We will bill your insurance for these services; however, should your insurance deny the charges as non-covered, you will be held ultimately responsible.
- I give consent to be contacted by my provider and their Designated Business Associates through any medium, including but not limited to wireless cell phone, email, and landline telephone. By providing your cellular number you are agreeing to be contacted by the provider and any entity working on the provider's behalf at the cellular number. And if necessary by an automated dialing or messaging system.

Printed Name of Patient: _____ Signature: _____

Relationship to Patient: _____ Date: _____

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We understand financial problems may affect timely payment, so we encourage you to communicate any such problems, so we may assist you in keeping your account in good standing.

Printed Name of Patient: _____ Signature: _____

Relationship to Patient: _____ Date: _____