Office and Financial Policies

We would like to thank you for choosing Midwest Orthopaedics at Rush, LLC (MOR) as your medical provider. To keep you informed of our current office and financial policies we ask that you read and sign our financial acknowledgement prior to any treatment. Please keep this document for future reference.

Credit Card Policy:

MOR requires a valid credit card or direct bank debit account information prior to services being rendered. Your credit card / bank account will not be charged until 60 days after the services provided have been processed by your health insurance carrier and the balance deemed your responsibility. You will be notified by letter and/or phone of any outstanding balances prior to MOR charging your card or account at which time we will inform you of all your payment options.

Cancelled Appointments: If you are unable to keep your scheduled appointment, please contact our office at least 24 hours prior to your appointment to reschedule your appointment.

No Insurance: Payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make prior arrangements with our Customer Service Representative or Financial Coordinator.

Insurance: Please bring your insurance card with you at the time of your appointment. For insurance plans that we contract with, your carrier requires that all co-pays be paid prior to any services being rendered. The co-pay requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. If you do not have your co-pay at the time of your visit, you must provide us a written waiver from your insurance carrier specifically authorizing MOR to waive this obligation.

You are responsible for any co-insurance, deductibles or non-covered services as required by your insurance. You will receive a statement from our office indicating what your insurance has paid. Any remaining balance is due upon receipt of that statement

High Deductible Health Plans: High Deductible Health Plans (HDHP) are consumer-driven health plans that have a minimum deductible and out of pocket limit that is set each year and adjusted for inflation, if necessary. If you have a HDHP, MOR requires a deposit fee to hold your surgical appointment. The deposit will be applied to whatever patient balance is not paid by your health insurance plan (such as deductibles, co-insurances, co-pays and/or non-covered services).

HMO or POS: For POS and HMO insurance plans that we participate in, your insurance carrier requires that you obtain a referral from your Primary Care Physician (PCP) before receiving services. Please bring that referral with you. Any services received without a referral or proper authorization will be your responsibility.

Auto Accident Injury: If your injury is due to an automobile accident, we request that you provide us with any information that will assist us in getting your medical claims paid. If your services are due to and/or are payable by a third party, MOR reserves the right to treat the third party as the primary payor. This information may include:

- a copy of the police report
- a copy of your auto insurance

- medical insurance
- names and information on other parties involved.

Payment for any services that we provide will ultimately be your responsibility if not paid promptly by another party.

Liability Injury: If your injury is a result of another party's negligence, we request that you provide us with any information that will assist us in obtaining reimbursement for the services rendered to you. If your services are due to and/or are payable by a third party, MOR reserves the right to treat the third party as the primary payor. This information may include:

- a copy of the accident report listing claim number and responsible party
- medical coverage and/or attorney information.

Payment for any services that we provide will ultimately be your responsibility if not paid promptly by another party.

Worker's Compensation: If your injury is due to an accident in your work place, please be sure to contact your employer and inform them of your injury. We will need to receive authorization from your employer before we can process any of your medical claims. Please have your employer contact our Worker's Compensation Department at 708-236-2631. Failure to properly report this injury to your employer may result in your claims being denied. Denied claims will be your responsibility.

Return Checks/Rejected ACH Withdrawals: A $30.00 charge will be added to your account for any checks returned or ACH withdrawals rejected by your bank for any reason in addition to any fees that your financial institution may charge you.

Disability or Insurance Forms: There will be a charge of $15.00 - $35.00 for the completion of medical forms (charge is based upon number of pages and complexity of information requested). Payment is due at the time that you pick-up the forms. Please allow 7 – 10 days for the completion of these forms. If you would like the forms mailed to you or your insurance company, payment will be due prior to mailing.

Medical Records: We will provide you a copy of your medical records upon request. You will need to sign a letter of release at the time of pick-up. Please allow 7-10 days for us to copy your records. If you wish for your records to be mailed, there may be an associated fee to cover the mailing costs. You may be charged for additional copies of your medical record. Rates charged are within Illinois state statutes.

X-Rays: We will provide you with a copy of your x-rays upon request. You will need to sign a letter of release at the time of pick-up. Please allow 48 hours from the time of your request. There is a $3.50 charge per x-ray, that is payable at the time of pick-up. If you have any questions or concerns, please contact our Customer Service Department at 312-432-2374.

Fracture Care: Fracture Care is billed out as a "packaged" service which includes the following: Evaluation, the **first** cast or splint application and 90 days of post-operative follow up care from the date of the fracture. There are some services that we bill separately which include: x-rays, all casting supplies, replacement cast applications, evaluations for any additional problems or injuries and treatment of complications. Your insurance carrier requires that we report our services using the coding system known as the *Current Procedural Terminology (CPT).* The codes for fracture care can be found in the *Surgery* section of the CPT book. This is not to imply that you will have or had surgery or that you will be or were taken to the operating room. This is how the CPT book was set up by the *American Medical Association* (AMA) for user-friendly purposes by both the insurance companies and physicians. Please note, your insurance company may cover these services for fracture care differently than office visits. Therefore, your services may be paid as a surgical procedure, with deductible and co-insurance guidelines applied. If you have any questions or concerns, please contact our Billing Department at 708-236-2607.

PATIENT NAME_____

Patient Financial Responsibility

I acknowledge full financial responsibility for services rendered by Midwest Orthopaedics at Rush, LLC (MOR). I understand that I am responsible for prompt payment of any portion of the charges including co-pays, deductibles and co-insurance amounts. I understand that payment of co-pays, deductibles and co-insurance amounts are expected at time of service, as well as any prior balance due that I may owe. I also consent that payment of authorized Medicare and any other insurance benefits may be made on my behalf directly to MOR for any medical or surgical services furnished. I agree to be responsible for all reasonable attorney fees and collection costs in the event of default of payment of my charges, as outlined in office and financial policy guidelines. I understand that in the event my services are due to and/or payable by a third party, (MOR) reserves the right to treat the third party as the primary payor. I also acknowledge that MOR reserves the right to seek payment as provided by the Health Care Services Lien Act (770 ILCS 21/1 et seq.) against any responsible third party.

Signed _____ Date _____

Consent for Purposes of Treatment, Payment and Healthcare Operations

I hereby give my consent to MOR to use or disclose, for the purpose of carrying out treatment, payment, or healthcare operations, all protected health information contained in the patient record of _____.

For a more detailed description of this consent and other uses and disclosures please review our Notice of Privacy Practices. I understand that MOR reserves the right to change its privacy practices that are described in the Notice. I also understand that any Revised Notice will be posted on MOR's website, available at each office or I may request a copy be sent to me by mail.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office

Signed _____ Date _____

Acknowledgment – Notice of Privacy Practices

I hereby acknowledge receipt of MOR's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential health information. I understand that MOR has reserved the right to change its privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided or made available to me.

Signed _____ Date _____

If you are not the patient, please specify your relationship to the patient _____