

Thank you for choosing Bayside Orthopaedic Center as your health care specialist. Our physicians are committed to the successful treatment of your condition. Payment of your bill is considered part of your treatment, and a clear understanding of our financial policy is important to our professional relationship. **Payment is due at the time of service.** We accept cash, check, or credit/debit cards for payment on your account. **Co-payment and Deductibles are a contract responsibility between the patient and their insurance company. These amounts are non-negotiable.**

**Insured Patients:** We will bill your insurance as a courtesy to you with a copy of your current insurance card. We will verify your coverage and inform you if a co-pay is due. Fees for non-covered services will be collected at the time services are rendered. It is our policy that we do not bill for co-payments since patients are expected to be aware of and prepared to pay them. **If your co-pay is not paid at the time of service, we reserve the right to charge an administrative fee of \$20.00 to your account.** After receiving your insurer's explanation of benefits (EOB) statement, if there remains an amount due, we will require that it be paid within 60 days.

**Uninsured Patients:** Patients without medical insurance coverage should expect to pay for their treatment in full at each visit, up to \$200. If charges exceed \$200, please see a Patient Services Representative to make arrangements for the balance. All uninsured patients are billed based on our Self Pay Fee Schedule. Our Patient Services representatives will design a repayment plan for you, based on our criteria and your ability to pay. All charges must be paid in full unless you have a signed payment plan.

**Motor Vehicle accidents, Third Party Liabilities – we do not bill auto insurance carriers or liability insurance carriers. We will be happy to treat you for your injuries, but you will be responsible for payment throughout your treatment. We will be happy to supply detailed billing forms for you to submit for reimbursement. You may wish to speak with your health insurance carrier about payment of these services in case of accidents.**

**Procedures and Surgeries –** some Healthcare policies levy a co-pay or co-insurance on the Physician's services. Co-Pays are due and payable on or before the procedure or surgery. Co-Insurance amounts will be collected after the insurance pays us and determines the amount you are to pay for co-insurance. You are a partner in keeping the cost of healthcare under control. For this reason, **all patient balances must be paid in full prior to having elective surgery or in-office procedures, including visco-elastic injections.**

**Delinquent Accounts:** Your account will be reviewed if payment is not received after 60 days and will be considered delinquent. **Any account found to be delinquent will be charged a \$25.00 late fee.** We reserve the right to send delinquent accounts to a collection agency. If that is the case, you will be responsible for any costs in connection with collection of a delinquent account. Collection agencies typically charge a 30 – 40% fee of the balance on the account. Non-payment of a delinquent account could affect your ability to schedule future appointments at Bayside Orthopaedic Center. \_\_\_\_\_ **(Please initial)**

**Additional Charges:** Checks returned for Non-sufficient Funds, Stop Payment, or Account Closed will be subject to a \$30.00 fee.

**Change of address:** Please update personal information with the business office. If a change of address cannot be found and a statement is returned by mail, the account will be turned over for collection. \_\_\_\_\_ **(Please initial)**

**Child Custody:** The responsibility for payment for services provided to any dependent children whose parents are divorced rests with the parent who seeks treatment. Any court-ordered responsibility judgment must be determined between the individuals involved without the inclusion of Bayside Orthopaedic, Sports Medicine & Rehabilitation Center, PC.

**Authorization: My signature indicates that I have read the above and am responsible for payment of fees.**

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**Patient, Parent or Legal Guardian (Signature)**

**Date**