

MEMORIAL BONE & JOINT CLINIC, LLP

Statement of Patient Financial Responsibility

Patient Name: _____

Date of Birth: _____

Memorial Bone & Joint Clinic, L.L.P appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill and payment is expected on the same day that services are rendered.

What you may need to pay:

There may be some costs you will have to pay. These healthcare expenses may include the following:

- **Initial Payment:** If you do not have insurance, we will collect \$250 for the initial exam. **This amount IS NOT the cost for the entire office visit.** The cost for the office visit will vary depending upon your condition and the services that are delivered. You will be billed for the visit less the \$250 initial payment.
- **Previous Balance:** You may have a balance that was not paid. This balance will be itemized on your Explanation of Benefits (EOB) provided to you by your carrier and we are able to provide an itemized statement for your review. It is your responsibility to pay this balance after any third parties have settled the account.
- **Co-pay:** The set amount you pay for each healthcare visit. The co-payment amount is determined by the contract with your carrier.
- **Co-insurance:** This is the percentage of healthcare costs you need to pay. If you have a co-pay or deductible, the coinsurance typically applies after the co-pay or deductible is paid. The co-insurance amount is determined by the contract with your carrier.
- **Deductible:** The amount you pay before your health plan begins to pay for covered services. The deductible amount is determined by the contract with your carrier.
- **Balance Billing:** If you use a doctor or other provider who is not in your network, you may have to pay more. The provider will bill you for this amount. While we will try to notify you if we are not in network with your carrier's plan, this is ultimately the patient's responsibility as noted in the contract between the patient and the carrier. Please contact your carrier to confirm that our services are considered in-network with your specific insurance plan. We will not accept responsibility for inaccurate information provided to our office or sudden changes in the contract between the patient and the carrier.

Please be aware:

- You agree to pay costs incurred by the Practice in collecting any amounts due including, without limitation, collection agency fees and attorney's fees.
- Healthcare costs are charged by the provider of the service. Additional charges may be assessed for physician orders, lab work, diagnostic tests and/or x-rays not performed in our office. **You may be billed separately by the lab, surgery center and/or hospital for their services.**
- If we are processing your claim through a third party, your pre-payments are only estimates. The final bill is determined once the claim has been processed. Your Explanation of Benefits will reflect all transactions.

I have read the above policy regarding my financial responsibility to the Practice, for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to the Practice, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient / Guarantor Signature: _____

Date: _____