

# ST. PETERS BONE & JOINT SURGERY, Inc.

## Patient Financial Policy and Notice of Privacy Practices Acknowledgement

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Thank you for choosing St. Peters Bone & Joint Surgery, Inc. for your orthopedic care. Our doctors and staff are committed to providing quality, affordable medical care without regard to financial status within a "value-for-value" framework.

We sincerely hope that by sharing our financial expectations we will strengthen the practice-patient relationship and keep the lines of communication open. This financial policy helps the practice provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact our Patient Accounts Specialist (636-229-4241).

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### **Self-Pay Accounts**

We designate accounts, **Self-Pay**, under the following circumstances: (1) patient is covered by an insurance plan that our providers do not participate in, (2) patient does not have a current, valid insurance card on file, (3) patient does not have a valid insurance referral on file, or (4) patient does not have health insurance coverage.

### **Payment is Due At the Time of Service**

- ❖ We accept cash, checks, debit, and credit cards.
- ❖ All co-payments and non-covered services are due at the time of service unless you have made payment arrangements in advance of your appointment. If you arrive without your co-payment, we may ask you to reschedule.
- ❖ Patient-responsible balances are due when you check in for your appointment.
- ❖ In the event you need surgery and you do not have health insurance coverage, we must receive down payment of no less than 50% of the estimated doctor's fees before we will schedule the surgery.

### **Proof of Insurance**

- ❖ Please bring your insurance card(s) with you to each appointment.
- ❖ It is your responsibility to inform the reception staff when the cause of treatment may be the responsibility of a third party - auto insurance, liability insurance company, worker's compensation – instead of your regular health insurance carrier. You are responsible to provide the office with all information required to bill the third party when you check in for your appointment.
- ❖ We will bill benefit-assigned claims to both the third party and your health insurance carrier for all services provided by our office at the same time – **one time only**. Should either insurance company reimburse you directly, we expect payment from you – in full – within 10 days of the receipt of payment. The patient is ultimately responsible for payment for any charges incurred.
- ❖ It is your responsibility to notify the practice of changes in your health insurance.

### **Referrals**

- ❖ If your insurance plan has a designated primary care physician (PCP) and you are required to obtain a written referral from that doctor, you must provide the office with that referral at the time of check-in. If you do not have a current, valid referral, we may ask you to either reschedule your appointment or pay for the visit at the time of service.

### **Our Responsibility to Report Non-Compliance**

- ❖ It is our obligation under many of the insurance contracts to report patients who: repeatedly refuse to pay co-payments/deductibles at time of service, or who repeatedly "no show" for appointments.

### **Financial Assistance**

- ❖ Our practice treats patients regardless of financial status. We offer assistance in the form of a sliding scale discount of charges based on verifiable household income, as well as affiliation with *CareCredit*, a healthcare credit card program.

## **Divorce and Child Custody Cases**

- ❖ In cases of divorce, the individual who seeks treatment of a minor child is responsible for payment of co-payments, coinsurance, deductibles, and nonparticipating insurance balances at the time of service. We will not bill a divorced spouse for the patient's services. The practice does not honor divorce specifics (*e.g., percentage of financial responsibility*).
- ❖ If the child has coverage with a participating insurance plan and the proper insurance identification is present at the time of service, the practice will bill that insurance company.

## **Billing, Payments and Refunds**

- ❖ All balances are due in full within 14 days of the statement date.
- ❖ It is your responsibility to notify the office of any change in address, phone, employment, or insurance coverage.
- ❖ If you make an overpayment on your account, we will issue a refund only if there are no other outstanding debts on other accounts with the same guarantor or financial responsible party.
- ❖ We reserve the right to report delinquent accounts to credit bureaus, assess a collection fee, take other collection action, or terminate you as a patient of this practice.

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## **Notice of Privacy Practices Acknowledgement**

I acknowledge that this is a summary of St. Peters Bone and Joint's Notice of Privacy Practices and consent to the use or disclosure of my protected health information by St. Peters Bone and Joint for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, to conduct health care operations of St. Peters Bone and Joint, and as required by law.

I also understand I may obtain a full version of the notice at any time, at my request. I understand my rights as a patient of this practice concerning my Protected Health Information (PHI), as it is outlined in this notice. I am aware St Peters Bone and Joint reserves the right to change the privacy practices that are described in this Notice of Privacy Practices by contacting the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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*Name of Patient or Personal Representative*

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*Signature of Patient or Personal Representative*

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*Date*

*DOB*

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*Description of Personal Representative's Authority*