OPA ORTHO
ORTHOPEDIC PHYSICIAN ASSOCIATES

FINANCIAL AGREEMENT

At Orthopedic Physician Associates, we are committed to providing you with the highest quality medical care. We realize you have choices for your medical care and we look forward to serving your orthopedic and neurosurgical needs.

PATIENT RESPONSIBILITIES

To ensure a more efficient experience, please assist us by:

- Providing us with your photo identification, insurance card and Social Security number to enable us to submit your claims timely and accurately
- Knowing your insurance benefits and limitations
- Confirming with your insurance carrier that any required referrals and prior authorizations have been approved
- Providing us with copies of any pertinent medical records, including tests (MRI, CT, Arthrogram and x-rays)
- Maintaining a current account with Proliance Surgeons
- Completing incident/accident forms (required by your insurance company) at the time of service
- Providing us with at least 24 hours advance notice should you need to cancel or reschedule an appointment (48 hours if an interpreter has been scheduled)

Please note that co-payments, co-insurance and deductibles are part of a contractual agreement between you and your insurance carrier and therefore, we are unable to change or negotiate these amounts.

INSURED PATIENTS

Co-Pays/Deductibles/Co-Insurance – Please be prepared to pay for your portion of the charges on (or in case of surgery, prior to) the date of service. Office procedures (e.g., casting, injections, radiology) will be billed separately from the office visit.

Non-Participating Insurance – If we do not participate in your insurance plan, we will file a claim as a courtesy. All unpaid claims will become your responsibility 45 days following filing and are immediately due and payable.

PRIVATE PAY PATIENTS

Office Visits – A $250.00 deposit is required prior to the appointment. If visits and services are paid in full at the time of service, we offer a 20% discount (see exclusions below). Office procedures (e.g., casting, injections, radiology) are separate charges from the office visit.

Surgery – For uninsured patients having surgery, we offer a 20% discount from our customary charges when services are paid before the day of surgery. This discount does not apply to cosmetic procedures, motor vehicle accidents, third party insurance claims or in other cases when the patient may be reimbursed in full.

If you receive retroactive Medicaid coverage, please immediately notify the OPA Business Office at (206) 386-2601.

WORKERS' COMPENSATION

If your care is related to a work-caused injury, please supply the date of injury, case number, case manager name and contact number, and carrier name prior to your visit. If your workers' compensation claim is not yet accepted and you have no other insurance, we require a $250.00 deposit that will be refunded after the claim has been paid.

SURGICAL FEES

Our surgical fee covers the professional services included in a standard surgery. OPA makes every effort to use assistants who are part of the OPA staff. On occasion, our surgical loads or staffing levels make it necessary for us to use outside assistants. Should that occur in your surgery, you may incur a separate billing for the assistant services. In addition, you may receive bills from other parties including but not limited to Seattle Surgery Center, Seattle Orthopedic Center, Swedish Medical Center, radiology, anesthesiology and durable medical equipment (DME).

OUT-OF-POCKET ESTIMATES

Prior to performing your surgery, we may contact your insurance company to obtain eligibility and an estimate of your benefits. Remember that this is an estimate only, based on proposed services and information supplied by your insurance carrier. Please be prepared to pay for your out-of-pocket costs at least one week prior to your surgery. (Please note that this does NOT apply to Medicare, Medicaid, federally insured, or workers' compensation patients.)

OTHER FEES AND POLICIES

No Show – Please provide us with at least 24 hours advance notice if you need to cancel or reschedule an appointment. We may charge a fee for missed appointments of up to $40.00. If an interpreter has been scheduled, please provide 48 hours to avoid being charged for the interpreter's no-show fee.

Forms – The completion of some forms may require payment and a signed Release of Information. Please allow up to two (2) weeks for our completion of these forms.

Monthly Management Fee – When your account reaches 45 days past due, a monthly management fee of $10.25 will be assessed to your account and for each month thereafter until the balance is paid in full.

Motor Vehicle Accidents and Third Party Liability Claims – We have special polices regarding motor vehicle accidents and third party liability claims. Please contact us for further questions.

PAYMENTS

Payment Options – We accept cash, checks, major credit/debit cards and money orders for payment (no post-dated or third party checks). We charge a $40.00 NSF fee for any returned checks.

Alternative Payment Arrangements – If you are unable to pay your balance when due, please contact our Business Office to make alternative arrangements. Any patient with a past due amount may be denied additional services until the amount is paid or has an approved alternative payment arrangement.

Collections – We may assign an account to collections if balances are unpaid after 60 days. Patients assigned to collections may be denied additional services.

Bankruptcy/Prior Bad Debt – Patients who have previously filed for bankruptcy or never satisfied their payment obligations for prior episodes of care with Orthopedic Physician Associates or other Proliance Surgeons care centers may be required to pay for their portion of new charges at the time of service.

Overpayments – Patient overpayments may be used to satisfy your outstanding OPA account balance or be transferred to other Proliance Surgeons care centers in order to resolve an outstanding balance.

I have read and understand the OPA Patient Financial Responsibility Agreement and have been provided a copy upon request.

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Signature of Patient or Responsible Party Date

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Patient Name (Please Print)