Office Policy
Nature Coast Orthopaedics & Sports Medicine Clinic

As your Healthcare providers, we are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance and your understanding of our office policy.

Medicare Since we are a Medicare provider, we will file your Medicare claims for you, however, your deductible and 20% of the allowable charges will be your responsibility.

Medicaid There is a $2.00 co-pay for each visit, except for children and pregnant women.

Health Insurance Co-pay will be collected at the time of service. As a courtesy, we will file your insurance claims for you; however, if payment is not made within 90 days the balance is then the patient's responsibility. Please be aware of your own Insurance Policy. Not all services are covered benefits. Some insurance companies select certain services they will not cover. Any services not paid by your insurance will be your responsibility. For New patients, a $300.00 deposit will be requested if your remaining unmet deductible is greater than $1,000.00. For Established patients, a $150.00 deposit will be requested if your remaining unmet deductible is greater than $1,000.00.

Self-Pay We ask for a $300.00 deposit on your first visit and a $150.00 deposit on all subsequent visits. We will bill the patient or responsible party the remaining balance after each visit. If the bills are less than the deposit, the patient will be refunded the amount due.

Auto Claims Florida is a no-fault state. We will file your claims to your auto insurance company. Your deductible and any unpaid charges will be your responsibility.

Worker's Compensation Your adjuster will need to call us prior to your first visit to give Authorization and proper billing information.

Liability / Legal Cases We do not accept liability cases or Letters of Protection.

Cancelled Appointments Patients who do not cancel appointments may be discharged from the practice after the third no show.

X-Rays Please allow us a minimum of 48 hours to prepare your x-ray copies. Digital copies will be places on a CD. There is a $10.00 charge to cover copying costs.

Medication Refills We require a minimum of 48 hours advanced notice for all refill requests.

Appointment Reminders We utilize email, text and voice messaging for appointment reminders. Indicate all options below that you authorize us to use to remind you of your appointments. Your signature below will authorize your options.

_____ Email Email Address_____

_____ Voice Messaging Telephone Number (_____)_____

_____ Text Messaging Mobile Telephone Number (_____) _____

I understand that this service is offered free of charge. However, standard text messaging rates from my mobile carrier may apply.

Signature: _____ DOB: _____

Release of Information To protect the privacy of our patients any time medical records are requested we do require a signed release from the patient, except in the case that the insurance being billed is requesting.

Please list below the names of individuals to whom we are allowed to provide patient information.
(In Example: Spouse, Children)

Name (Please Print)	Relationship (Optional)
_____	_____
_____	_____
_____	_____
_____	_____

Please list below the names of individuals to whom are allowed to pick up prescriptions on your behalf.
(In Example: Driver, Neighbor)

_____ _____

We must emphasize that as your Healthcare providers, our relationship and concern are with you and your health, not your insurance company. All charges are your responsibility from the date services are rendered. On any balance on your account after 90 days, including those that insurance has not paid, collection action may be taken. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I hereby authorize my insurance benefits to be paid directly to my assigned provider / physician, realizing I am responsible to pay non-covered services. I also hereby authorize the release of pertinent medical information to insurance carriers.

I have read and understand the above Office Policy.

Print Name: _____ DOB: _____

Signature: _____ Date: _____

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