



1950 Bluewater Blvd., Suite 100
Niceville, FL 32578
(850) 897-8081
FAX: (850) 897-1520

7720 Highway 98 W., Suite 200
Destin, FL 32550
(850) 622-3713
FAX: (850) 622-3721

120 E. Redstone Ave., Suite B
Crestview, FL 32539
(850) 398-8600
FAX: (850) 331-221

FINANCIAL POLICY

1. **PAYMENT** is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. We do ask for a copy of an ID card of license due to the many cases of identity theft in the news lately. (Please do not be offended!)
2. **DIVORCED PARENTS of PATIENTS:** The adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.
3. **SURGERY:** Payment in full is expected at the time the surgery is scheduled. All insured patients are expected to pay their patient responsibility, surgical co-pays, co-insurance percentages, and unsatisfied deductibles. The charges are for the surgeon's fee only and will not include anesthesia, facility fees, or other services rendered in conjunction with your surgery. Payment options are available upon approval.
4. **NON-INSURED PATIENTS:** A 20% prompt pay discount is applied to all full pay payments received at the time of service. This means anyone willing to/or needing to pay in full at the time of service will receive the 20% discount off of the services provided.
5. **INSURANCE:** We are participating providers with several insurance plans. We will file all of these insurance claims. A list of these insurance plans is available upon request. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment for your insurer, we will refund any overpayment to you. If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge whether a participating insurance plan or non-participating plan. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.
6. **RESPONSIBILITY FOR PAYMENT:** I understand that I, personally, am financially responsible to **BLUEWATER ORTHOPEDICS, PA** for charges not covered by the assignment of insurance benefits.
7. **COLLECTION FEES:** I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.
8. **RETURNED CHECKS** will incur a \$45.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the \$45 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the \$45 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in Okaloosa County.
9. **ACCOUNTING PRINCIPALS** Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.
10. **FORMS FEES:** completing insurance forms, copying medical records, etc... Requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, notarizing, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. Copying fees for Medical Records is \$25 for the first twenty-five (25) pages and \$0.25 per page in excess of twenty-five. Copying fees for Workman's Compensation or Attorney claims is \$0.50 per page for the first twenty-five (25) pages and \$0.25 for each additional page in excess of twenty-five (25). **BLUEWATER ORTHOPEDICS, PA** will have 15 business days in which to copy records before making them available for patient to pick up, and these 15 days will commence after payment for copying has been received and after patient has signed this form authorizing records' release.
11. **RELEASE OF INFORMATION:** I hereby authorize the and direct **BLUEWATER ORTHOPEDICS, PA** to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

Patient Signature

Date