Office Policy
Nature Coast Orthopaedics & Sports Medicine Clinic

As your Physician, 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.

Self-Pay We ask for a $200.00 deposit. We will bill the patient or responsible party the remaining balance. If the bills are less than the deposit, the patient will be refunded the amount due. Unless other payment arrangements are made with our billing department, payment is due when services are rendered.

Auto Claims We will file claims for you with accident related insurance company, however, 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 If a properly executed Letter of Protection is received from your attorney; payment in full is expected at time of settlement. If no Letter of Protection is received from your attorney, your account will be treated as a self-pay if there is no insurance coverage.

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. You may be charged for copying costs. You will be notified of applicable charges before copies are made.

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.

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

We must emphasize that as your medical providers, our relationship and concern is 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 insurance benefits and Office Policy.

Print Name: _____

Signature: _____ Date: _____

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