CONNECTICUT FAMILY ORTHOPEDICS, P.C.
33 HOSPITAL AVENUE
DANBURY, CT 06810
(203) 792-5558
FAX# (203) 731-3213

.

Financial Policy

The doctors and staff of Arthritis Associates, a Division of Connecticut Family Orthopedics, P.C. are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

YOUR INSURANCE

You, as the responsible party, must furnish our office with up-to-date insurance information. A copy of your insurance card will be made. Report any changes in insurance coverage immediately upon arrival.

WE ARE A SPECIALIST PRACTICE. IF YOUR INSURANCE PLAN REQUIRES A REFERRAL FOR YOU TO COME TO OUR OFFICE, YOU ARE RESPONSIBLE FOR OBTAINING THAT REFERRAL. FAILURE TO DO SO MAY MEAN THAT YOU WILL NOT BE SEEN UPON ARRIVAL IN OUR OFFICE.

We are contracted (participating) with many health plans. If your plan is one of those, we will collect any required copays when you arrive for your appointment. Our office will file a claim with your insurance for the day's charges. Any amounts that you are responsible for once your insurance has paid, will be billed to you. In the event your insurance determines services to be "NON COVERED", you will be responsible for the complete charge. Payments are due upon receipt of a statement from our office.

If you have insurance coverage with a plan with which we do not participate, as a courtesy, we will prepare and submit the claim to your insurance carrier. In order for the doctor to receive payment directly, you must have a signed "Assignment of Benefits " form on file. If your annual deductible and out-of-pocket maximum have not been met, we expect payment on the date of service. Any balances are your responsibility and due upon receipt of a statement from our office.

We will also bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of statement from our office.

MEDICARE

Medicare patients are responsible for their annual deductible, co-payments and charges for non-covered services.

SELF-PAY PATIENTS

Patients without insurance are offered a 20% discount if payment is made at check-out on the date of service. Acceptable forms of payment are cash, check, and all major credit cards.

MINOR PATIENTS

An adult must accompany minor patients in order for treatment to be rendered and to provide insurance information. The adult accompanying the minor child is responsible for payment if the patient is uninsured.

MISSED APPOINTMENTS

In order to provide the best possible service and availability to our patients, those patients who fail to cancel an appointment in advance of the time scheduled by at least 24 hours will be charged a fee of $25.00.

MOTOR VEHICLE ACCIDENTS

If you have Medpay on your Auto Policy, we will bill your auto insurance carrier. Any balances not covered by your auto insurance are your responsibility.

PAST DUE ACCOUNTS

Accounts not paid in a responsible manner will be referred to an outside agency for collections and will reflect on your credit rating. In the event the account is sent to collection, you will be responsible for attorneys' fees, if applicable. Please call our Business Office at (203) 792-5630 if you have financial issues and wish to set up a payment plan. You will be able to make monthly payments toward your balance and avoid the collection process.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand that such terms may be amended from time-to-time by the practice. I hereby authorize Arthritis Associates, a Division of Connecticut Family Orthopedics to release any information acquired in the course of my examination and treatment, to any person or corporation, including but not limited to hospital service companies, insurance carriers, workmen's compensation carriers, welfare funds or employer providing such agent has a financial liability to my treatment at Arthritis Associates, a Division of Connecticut Family Orthopedics, P.C. I hereby authorize the physician and/or physician assistant to administer such treatment and medication as may be deemed necessary or advisable in the treatment and diagnosis of my condition. This authorization is given voluntarily and I hereby acknowledge that no guarantees have been made to me as to the results of treatments or examinations at Arthritis Associates, a Division of Connecticut Family Orthopedics, P.C.

Print Name of Patient

Signature

Date

Relationship to Patient