



CONCORD ORTHOPAEDICS

Financial Policy

Medical Insurances:

We participate with and bill the following insurances: Aetna, Anthem, Cigna, Harvard Pilgrim HealthCare, HealthCare Value Management, Medicare, MVP Healthcare, NH Medicaid, Private HealthCare System, One Health Plan, Oxford Health Plan, Tufts HMO, United HealthCare, CompNet PPO and Choice Care Network.

We will make a reasonable effort to bill other insurance companies; however, there may not be any benefits or limited benefits for services provided by our physicians. Please be advised that it is your responsibility to contact your insurance company to determine your coverage prior to treatment.

Managed Care Insurances:

Our physicians may not be authorized to provide service for patients with managed care insurance without a referral from a primary care physician. Please contact your primary care physician for a referral authorization. If you do not have authorization prior to your appointment, you will be asked to sign a waiver accepting responsibility for payment should authorization be denied.

Some managed care plans allow you to obtain treatment without a referral. When you choose this option, there is usually an increased out of pocket expense to you.

Payment at Time of Service:

If you have no medical insurance, payment in full is expected at the time of service. Co-payments and co-insurances are due at the time of service. Patients with previous uncollectible balances are expected to pay before the provision of services.

In liability cases, we expect payment in full at the time of service and do not bill attorneys.

We accept cash, checks, debit cards, MasterCard and Visa.

Minors:

It is our policy that the individual who brings a child/minor into our office and consents to treatment for services is accepting full responsibility for any balance due for services rendered.

I authorize assignment of insurance benefits to Concord Orthopaedics for the purpose of payment towards services rendered by Concord Orthopaedics.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for my account for any professional services rendered.

I have read this **FINANCIAL POLICY** and verify that all the insurance information that I have provided to Concord Orthopaedics is true, accurate and complete to the best of my knowledge.

Patient **Printed** Name: _____ Date of Birth: _____

Patient/Parent/Guardian **Signature**: _____ Date: _____