Name:
DOB:
Chart:
Age:
Date:

BAYSIDE ORTHOPAEDIC
SPORTS MEDICINE & REHAB CENTER

TREATMENT CONSENT/FINANCIAL POLICY

Thank you for choosing Bayside Orthopaedic Center as your health care specialist. Our providers are committed to the successful treatment of your condition. I hereby authorize the doctor and the associates or assistants of his/her choice to treat my/the patient's condition, this also includes the treatment of a minor (under the age of 18). I understand that possible risks are present in any treatment or procedure that may be performed, and that my/the patient's physician will explain these prior to initiating any treatment or performing any procedure. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon me. I agree that Bayside Orthopaedic Sports Medicine & Rehab Center can request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Payment is due at the time of service. Co-payment and Deductibles are a contract responsibility between the patient and their insurance company. These amounts are non-negotiable.

Insured Patients: We will bill your insurance as a courtesy to you with a copy of your current insurance card. Fees for non-covered services will be collected at the time services are rendered. It is our policy that we do not bill for co-payments since patients are expected to be aware of and prepared to pay them. After receiving your insurer's explanation of benefits (EOB) statement, if there remains an amount due, we will require that it be paid within 60 days. If your insurance coverage should change during the course of treatment, you should notify Bayside Orthopaedic immediately.

Uninsured Patients: Patients without medical insurance coverage should expect to pay for their treatment in full at each visit, up to $200. If charges exceed $200, please see a Patient Services Representative to make arrangements for the balance. All uninsured patients are billed based on our Self Pay Fee Schedule. Our Patient Services representatives will design a payment plan for you, based on our criteria and your ability to pay. All charges must be paid in full unless you have a signed payment plan. Delinquent accounts that are turned over to outside collections will be charged the full fee for all services.

Motor Vehicle accidents, Third Party Liabilities: we do not bill auto insurance carriers or liability insurance carriers. We can treat you for your injuries, but you will be responsible for payment throughout your treatment. We can supply detailed billing forms for you to submit for reimbursement. You may wish to speak with your health insurance carrier about payment of these services in case of accidents.

Procedures and Surgeries: Our Patient Services team will provide a Financial Estimate for procedures and surgeries. This will be determined by looking at co-insurance and deductibles on each individual policy. A 50% deposit will be required before any elective surgery or in-office procedure, including visco injections. The remaining balance will be billed on the date of service.

Delinquent Accounts: Your account will be reviewed if payment is not received after 60 days and will be considered delinquent. We reserve the right to send delinquent accounts to a collection agency. If that is the case, you will be responsible for any costs in connection with collection of a delinquent account. Collection agencies typically charge a 30 – 40% fee of the balance on the account. Non-payment of a delinquent account could affect your ability to schedule future appointments at Bayside Orthopaedic Center.

Additional Charges: Checks returned for Non-sufficient Funds, Stop Payment, or Account Closed will be subject to a $30.00 fee.

Change of address: Please update personal information with the business office. If a change of address cannot be found and a statement is returned by mail, the account will be turned over for collection.

Telephone Consent: I give consent to be contacted on my wireless phone number (call or text) regarding billing, collections, and appointment reminders.

No Show Charge: I understand any appointment I have must be cancelled or rescheduled 24 hours or more in advance or I will be charged a fee of $25.

My signature authorizes that I have read the above and understand treatment consent and the financial policy.

Patient, Parent or Legal Guardian (Signature) **Date**