

Financial Policy

Thank you for choosing VOS as your health care provider. We are committed to the successful treatment of your condition. Payment of your bill is considered part of your treatment and a clear understanding of our financial policy is important to our professional relationship.

We will bill your insurance as a courtesy to you with a copy of your current insurance card. If you do not have your insurance card, full payment is due at the time of service. We accept cash, check, credit, and debit cards. There will be a \$25 charge for returned checks. If payment is not received from your insurance carrier within our contract limits, any balance will be your responsibility.

Medicare: We accept Medicare assignment. As a Medicare patient you are responsible for your deductible and for the difference between the approved charge and the amount Medicare pays. If you have supplemental insurance we will bill it for you. Any remaining balance will be billed to you.

HMO/PPO/Commercial: All co-payments are due at the time of service, we are members of most, but not all plans. You are responsible for verifying what your insurance plan will cover and that we are providers for your plan.

Workers Compensation: If you are here as a result of work related injury, we will require information regarding both health insurance and your employers Workers Compensation insurance. We will require a letter or statement authorizing your treatment from your employer or WC carrier. The letter should include the claim number, address, adjusters name and phone number. Your employer's human resource office should be able to assist you with obtaining this information. If payment is not received, the balance is your responsibility.

Accident Claims: If you are here as a result of an auto related injury, we will require information regarding both health insurance and your auto insurance. We will require a letter or statement authorizing your treatment from your auto insurance. The letter should include the claim number, address, adjusters name and phone number. Your auto insurance agent should be able to assist you with obtaining this information. If payment is not received, the balance is your responsibility.

UCR (USUAL AND CUSTOMARY RATE): We are committed to provide the best treatment possible for our patients and we charge what is usual and customary for our area. If we do not have a contract with your insurance company, you are responsible for payment in full regardless of any insurance company's arbitrary determination of UCR rates.

Self Pay: A minimum deposit of \$200 or the actual charges, whichever is less, is due at the time of service for all self-pay patients. Currently VOS offers a 20% prompt pay discount on charges paid in full at time services are rendered. Any subsequent visit charges will be due at time of service. If you cannot pay in full, you will need to set up and adhere to a payment plan with our billing department. We accept Visa, Master Card, Discover, American Express, Checks and Cash.

Delinquent accounts: Delinquent accounts may be assigned to a collection agency. All collection costs will be added to your outstanding balance. We cannot be involved in negotiating payment for divorce orders for medical bills. Whichever parent brings the minor child in for treatment will be responsible for payment of the bill regardless of your divorce decree.

Forms Completion/Medical Records Requests: From time to time various forms including but not limited to disability and FMLA forms need to be filled out. There will be a \$10.00 charge to complete these forms. There is a nominal fee for copying medical records in accordance with the state allowance. There is a \$5.00 per film charge to copy x-rays.

Consent for Medical Treatment: I authorize physicians and personnel to render medical treatment and evaluation if needed for this appointment and all future appointments. I further authorize X-rays, injections, casting, or other diagnostic tests and treatments that may be necessary.

I have read and understand the payment policies set forth and have been given the opportunity to ask questions about this policy. I understand my responsibility for payment of my account with VOS and have provided to the best of my ability the information requested accurately and completely.

Signed (patient, parent or authorized individual)

Date