Revised May 4, 2006

Rowe Orthopaedic Center – Financial Policy

We are committed to providing you with the best possible care. Your clear understanding of our financial policy is important to our professional relationship.

Insurance Contract: While the filing of insurance claims is a courtesy we extend to our patients, your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. It is your responsibility to provide us with current medical cards. It is very important that you understand the provisions of your policy. We cannot guarantee payment of your claims. If your insurance company pays only a portion of the bill or rejects your claim, any contact or explanation should be made to you, their policyholder. Reduction or rejection of your claim by your insurance company does not relieve you of your financial obligation with Rowe Orthopaedic Center.

Insurance Benefits: Not all services are covered benefits in all contracts. Insurance companies select certain services they will not cover. Some, and perhaps all, of the services rendered may be considered "non-covered services". It is the responsibility of the subscriber to know the policy provisions and seek appropriate approval before receiving services.

Managed Care: If you have a managed care medical insurance that we participate with, your payment of deductibles, co-payments, and non-covered services are due when services are rendered. If we do not participate with your insurance company or if you do not have health insurance coverage, payment for services is due at the time services are rendered. We accept cash, check, money order, Visa, and MasterCard.

Prior Authorization: If your insurance company requires prior authorization from a primary care physician, you must provide proof of authorization at the time of service or you may be asked to reschedule the appointment.

Monthly Statements: If a personal balance occurs on your account, a monthly statement will be mailed to you with payment in full expected within 30 days. We accept cash, check, money order, Visa and MasterCard. ***Patient /Guarantor agrees that, if collection efforts and/or legal proceedings become necessary for Rowe Orthopaedic Center to collect any balance due, Patient /Guarantor agrees to indemnify and hold harmless Rowe Orthopaedic Center for any costs of collection including collection agency fees (32%), court filing, service fees, and actual attorney's fees.***

Returned Checks: Any returned check is subject to a $25.00 service fee.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment will be the responsible party for those subsequent charges. If the divorce decree requires another parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. Our office will not take part in those negotiations.

Medical Records: The required fee for medical records is regulated by the Medical Records Act of 2004 and is posted in our office.

Form Completion: Requests for the completion of forms (Disability, life insurance, FMLA, etc.) will be charged a fee of $20 per form. This will be paid via cash, check, money order, Visa or MasterCard prior to physician completion.

I hereby authorize the consent for treatment by the staff at Rowe Orthopaedic Center.

I, the undersigned, certify that I (or my dependent) have insurance coverage with the provided insurance companies and assign directly to Rowe Orthopaedic Center, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the physician to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I accept that it is the policy of Rowe Orthopaedic Center to dismiss any patient that has accumulated three or more no-showed appointments. I also give permission for HIV testing, in the event that a physician or staff member be exposed to my blood or bodily fluids. I have read and understand this policy of Rowe Orthopaedic Center. I also understand that such terms may be amended from time to time by the practice. ***Failure to recognize this policy does not negate your responsibility.***

Patient Name ______________________________ Date ______________

Signature of Patient / Guarantor ______________________________