SCRANTON ORTHOPAEDIC SPECIALISTS P.C.
PATIENT AND FINANCIAL POLICY INFORMATION

Thank you for choosing us as your health care provider. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

SELF PAY/NON-PAR INSURANCES: The patient is responsible for payment of all services when they are rendered. We do accept Visa and Mastercard. If we do not participate with your insurance, a statement containing all the necessary information to bill your insurance will be given to you. You will simply attach the statement to your own claim form for reimbursement.

WE DO PARTICIPATE WITH THE FOLLOWING INSURANCE CARRIERS:*All non covered services and copayments for the carriers listed below are due at time of service.* ALL MEDICARE PLANS AND CHAMPUS. Medicare Advantage plans we participate with currently are GHP Gold and Aetna. We participate with ALL PA BLUE SHIELD PLANS INCLUDING ACCESS CARE II, PREMIER BLUE &Federal BS. (Should you have an income limit plan, you will be required to provide us with your most recent tax return to verify income). Also participate with FIRST PRIORITY HEALTH, GHP, CIGNA, CENTRAL PA TEAMSTERS, MEDICAL ASSISTANCE/MED PLUS and Aetna.

COLLECTION OR OPEN BALANCES: If you have a balance in collection or an open balance for previous services, the office may use their discretion as to seeing you again. It may be required that you pay your previous balance prior to being seen. If you are seen, you will also be responsible for any services that were performed on that day. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 60-90 days, the balance will be your own personal responsibility.

DISABILITY FORM PREPARATION: The fee is usually $5.00 per form but additional fees may apply depending on the type of form. We will try to complete your forms as quickly as possible, however they may take 5-10 days to complete.

PATIENT PHYSICIAN AGREEMENT STATEMENT: I understand that I am entering into a contractual relationship with Scranton Orthopaedic Specialists for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Scranton Orthopaedic Specialists, I and/or my representative agree not to advance directly or indirectly any false, meritless and/or frivolous claim(s) of medical malpractice against any provider at Scranton Orthopaedic Specialists.

Furthermore, should a meritorious medical malpractice case of cause of action be initiated or pursued, I and/or my representative agree to use an American Board of Medical Specialty board certified expert medical witness in the same or similar specialty as my physician. Furthermore, I agree that these expert witnesses will adhere to the guidelines and/or code of conduct defined by the specialty for expert witnesses in the area of medicine that would typically have the background and experience to give their opinion on such a case.

MINOR PATIENTS: The parent or guardian accompanying a minor child is responsible for payment. We must have pre-approval from a parent or guardian for an unaccompanied minor before treatment can be rendered.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X____Date ___________________
Signature of Patient or Responsible Party