The ORTHOPAEDIC CENTER

Bell III Building
1809 East 13th Street, Ste 100
Tulsa, OK 74104-4243
918-582-6800
918-582-6060 fax
www.toctulsa.com

FINANCIAL POLICY

Payment is due at the time services are rendered 72 hours prior to scheduled procedures; this includes self-pay, insurance co-pays and/or deductibles. A current insurance card must be presented at each office visit. As a service to our patients, we will file your medical claims for the date-of-service with insurance information we have available at that time. It is your responsibility to inform us of any changes in your insurance or personal information, such as address and/or phone changes.

Accounts with balances are considered past due at 31 days without a payment. Once an account is delinquent, it may be considered for collection procedures and placed with an independent agency. Should your account be turned for collection procedures, all future services will be suspended until financial matters are resolved.

We realize information surrounding health care and insurance can be difficult and confusing at times, that is why we are here to assist in this process as you seek to improve your health. If you have any questions or should you feel that you cannot meet the terms set forth with the Financial Policy, please feel free to contact us at 918/582-6800. Again, thank you for choosing The Orthopaedic Center. We look forward to serving you.

PLANS

I hereby assign and convey directly to The Orthopaedic Center, P.C, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by The Orthopaedic Center, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize The Orthopaedic Center to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to The Orthopaedic Center all Plan documents, summary benefit descriptions, insurance policies, and/or settlement information upon written request from The Orthopaedic Center or its attorneys in order to claim such medical benefits.

Patient: _____ DOB: _____ Initials: _____

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to The Orthopaedic Center, P.C. any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from The Orthopaedic Center (including any right to pursue those legal or administrative claims or chose an actions). This constitutes an express and knowing assignment of ERISA breach of fiduciary claims and other legal and/or administrative claims.

I intent by this assignment and designation of authorized representative to convey to The Orthopaedic Center all my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or medications provided by The Orthopaedic Center, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The Orthopaedic Center, PC is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The Orthopaedic Center, PC as my assignee and my designated authorized representative, may sue any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense. Unless revoked, this assignment is valid for all administrative and judicial reviews under Patient Protection Act/Affordable Care Act (health care reform legislation), ERISA, Medicare and applicable federal and state laws and local.

Fracture Care Policy

If one of our orthopaedic providers diagnoses you, your child, or someone you brought to the clinic with a fracture, the treatment of a fracture includes the clinical exam, x-rays, reading of x-rays, casting/splinting, and following this injury until it has healed.

The charges associated with the care of a fracture (closed treatment of a fracture) are listed as a single charge. The code number and charges associated with this were developed by Medicare guidelines and your insurance company, not by our office. Your explanation of benefits from your insurance company may describe it as a "surgery", but it is not a surgery, but a closed (non-surgical) treatment of the fracture.

The charge for this fracture is a single charge that includes 90 days for follow up care, also known as the global period. You will not be charged for an office visit every time you visit the provider during this 90 days since this is included in your initial fracture care exam and fees. However, there are additional charges for x-rays, casting and materials, and/or braces/splints that are not covered with the fracture fee.

Assignment of Benefits

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including private insurance to THE ORTHOPAEDIC CENTER. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits.

Again, thank you for choosing The Orthopaedic Center. We look forward to serving you.

"I have read, understand and agree to the provisions of this Financial and Fracture Care Policy."

Signature: _____ Date: _____

Patient: ____ DOB: ______________________