MOTIONORTHOPAEDICS

633 Emerson Road
Creve Coeur, MO 63141
P# (314) 991-2013 F# (314) 991-2006

Thank you for choosing Motion Orthopaedics. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** Our providers participate in many insurance plans, including Medicare. If you are not insured by a plan your provider is contracted with, payment in full is expected at each visit. If you are insured by a plan your provider is contracted with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility.** If your insurance plan requires you to have a referral, it is your responsibility to receive this referral from your primary care provider BEFORE your appointment. Please contact your insurance company with any questions you may have regarding your coverage. Their phone number can usually be found on the back of your insurance card.

2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This is required by your insurance plan as part of your contract with your insurance company.

3. **Non-covered services.** Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. (For Medicare patients, you must sign an Advance Beneficiary Notice of Noncoverage (ABN). For contracted plans, the claim will be processed with the insurance company before patient is billed - per our contracts).

4. **Proof of insurance.** All patients must complete our patient information form before seeing a provider. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. We must have copies and information for both your Primary and Secondary insurance plans.

5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance may automatically be billed to you.

7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter asking you to contact our Billing Service within 10 days of the date on the letter to make payment in full. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care.

8. **Missed appointments.** Our policy is to charge for missed appointments. Any appointment that is cancelled within 24 hours of the time of your appointment will be charged $50.00 for that missed appointment. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

9. **Payments.** We accept cash, check, certified check, MasterCard, Visa, American Express and Discover cards as a form of payment. There will be a $25.00 fee for all returned checks.

10. **Telephone Consumer Protection Act (TCPA).** I agree that the facility, Motion Orthopaedics or any other collection or servicing agency or agencies retained but the facility (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voicemail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or otherwise associated with my account.

Our practice is committed to providing the best care possible to our patients. Our charges are based on data regarding the usual and customary charges for our area.

Thank you for reviewing our financial payment policy. Please let us know if you have any questions or concerns.

Please note: The physicians of Motion Orthopaedics do not consent to audio or video recordings of any kind during evaluation and treatment. We kindly ask that you silence your phone and refrain from usage during your exam.

I have read and understand the financial payment policy and agree to abide by its guidelines:

☐ By checking this box I affirm my intent to sign this form electronically by typing my name below.

Signature: _____ DATE: _____