Patient Privacy Notice & Payment Policy

CURR_DATE_FS] [USER_NO] Subject to change without notice

Advanced Orthopaedic Associates, PA
9828 E. Shannon Woods Street, Suite 100
Wichita, KS 67226
316-631-1600 - www.AOAortho.com
Billing Dept: 316-631-1699

Patient Name:
Date of Birth:
MR#: **Account#:**
Appt. Date:

Financial Responsibility- Payment is due at time of service. We accept cash, checks, debit cards, and all major credit cards. We accept Blue Cross, Medicare, Work Comp, most HMO's and PPO's and many insurance networks. **We do not accept Out-of-State or Federal work comp.** Out-of-network insurances may result in higher out-of-pocket costs for you. If you have an unmet high deductible, payment is due at time of service. Please pay any co-pays at time of service. Your bill might include office visits, x-rays, surgeon fees, assistant surgeon fees (PA, APRN, etc), orthotics, casting, or other charges. We are willing to make short-term payment arrangements. Accounts should be fully paid within 1 year. Failure to honor your payment arrangement makes your balance immediately due in full. We have the right to file a lien on your account. You are responsible for collection costs including check fees, collection agency fees, attorney fees and court costs. Records copying, legal, and other special services have a separate fee schedule and require prepayment. Form preparation is $20 per form.

What if I don't have insurance (Self Pay)- Self-pay patients must pay **$150** towards 1st visit; **$75** is due at subsequent visits unless arrangements are made. You will be billed for any balance due or refunded any overpayment. Self-pay guidelines apply if you have auto insurance coverage but no other medical insurance. Self-pay guidelines apply for office charges if you have an unmet deductible > $1,000. Emergent patients referred through the ER are seen regardless of payment arrangements (refer to EMTALA guidelines).

What if I need surgery and have a large deductible or no insurance - Self-pay surgery patients and patients with an unmet deductible >$1,000 must make a down payment when surgery is scheduled and sign a payment agreement for any balance. Remaining balances will be billed or overpayments refunded. Please be sure we have accurate insurance information.

What if my insurance requires a referral- Please confirm your insurance network, including referral requirements, before your visit and before surgery. You must obtain any required referral from your PCP or employer. If you were injured at work, you will need prior authorization from your employer for a work comp claim to be filed. Please bring prior medical records and referrals to your appointment or fax to 316-631-1617. If we have not received your referral at the time of your visit, please call to obtain it. If you are not able to obtain the referral, you may sign a waiver and pay for the visit, or you may reschedule your appointment.

What if my insurance does not pay- We file your insurance, but the best way to maximize your insurance benefit is to stay involved with your insurance company. Please call your insurance company if your bill is not paid promptly. By Kansas law, insurance claims should be paid within 30 days of claim filing (KSA 40-2442). Failure to follow-up/respond to your insurance company requests for information will result in the bill becoming your responsibility. Payment is due even if you are in litigation.

What Should I Bring to My Office Visit- Please bring your insurance card, any co-pay, a Photo ID, and relevant medical records to your office visits. Check your insurance for co-pay and/or referral requirements. We may contact you using technology such as cell phones and/or text messages. This may include visit reminders and non-marketing calls by or on behalf of AOA by our associates.

What if My Child Needs to See the Physician- A biological parent or legal guardian must accompany patients who are minors on the patient's first visit or bring the Consent to Minor form. This accompanying adult is responsible for payment on the account.

Authorization for Care- I grant permission for AOA to render such care that my physician may deem necessary in my diagnosis and treatment. I understand that care may include medical and surgical treatment, and diagnostic tests.

Authorization for Release of Information- I hereby authorize AOA to disclose necessary information from the patient's medical records to the **parties listed below** when requested for the purposes as stated herein; to any physician for the purpose of providing continuing professional care and to any insurance company or third party payor for the purpose of obtaining payment to AOA for the services provided. AOA, its employees, and agents are released from legal responsibility or liability for the release of above information to extent indicated and authorized herein. I understand this release specifically includes any and all blood and related tests including test results reflecting presence of HIV, HBV, and the diseases, all of which I specifically authorize to be released.

Parties that are authorized to receive medical information other than the patient & patient's doctor(s).

_____ **/ Relation to patient**_____
(please print)

_____ **/ Relation to patient**_____
(please print)

_____ **/ Relation to patient**_____
(please print)

Patient Privacy Act- I acknowledge that the Notice of Privacy Practices of Advanced Orthopaedic Associates has been offered to me and I understand that it is available upon request at any time.

WITH THIS SIGNATURE BELOW I ACKNOWLEDGE ALL THE INFORMATION ABOVE.

x_____ _____ _____
Signature of Patient or Representative | Relationship | Date