



McKinley
Orthopedic & Sports Medicine

OFFICE PAYMENT POLICY

OFFICE PAYMENT POLICY: Patients are responsible for payments of services rendered. Please read this form carefully and have questions answered before signing.

CASH ACCOUNT: Payment is expected in full unless other arrangements have been made.

INSURANCE: We are contracted ONLY with Blue Cross and Aetna. You are ultimately responsible for your bill. It is your responsibility to check your coverage thru your insurance. We will bill primary and secondary insurance as a courtesy. Patients are asked to pay the full amount of deductibles and co-pays at the time of each visit. Any overpayments will be refunded to the appropriate party.

- **Chief Andrew Isaac Health Center:** Patients are required to bring a purchase order from Contract Health for each visit. If no purchase order is received the patient will be responsible for full payment at the time of the visit.
- **Medicaid:** Please be prepared to pay your \$3.00 co-pay at the time of your visit.
- **Medicare:** Please remember there is yearly deductible and possible co-pay for each visit.
- **Veteran’s Administration:** Prior authorization is required before each visit. This is the patient’s responsibility. If no authorization is received the patient will be responsible for full payment at the time of visit.
- **Workers Compensation:** Paperwork from your employer is required upon the first visit. There will be no retroactive filing done by our office.

Insurance is a contract between you and your insurer. We will be happy to help if we can, but will not become involved in disputes concerning deductibles, co-pays, secondary insurance, or “usual and customary” reductions.

DELINQUENT ACCOUNTS: Past due accounts will be referred to Cornerstone Credit Services for collection. Once an account is placed with **Cornerstone**, all questions must be directed to their office at 1-907-770-8100. We will not be liable for any consequences which may result from a collection agency effort to obtain payment.

I authorize direct payments of benefits from my insurance to McKinley Orthopedics & Sports Medicine and/or McKinley Sports Medicine for services rendered. I hereby authorize McKinley Orthopedic & Sports Medicine and/or McKinley Sports Medicine to release to my insurance company any information required to process a claim on my behalf. Photocopies of this form are to be considered to be as valid as the original. I understand I am financially responsible to McKinley Orthopedics & Sports Medicine and/or McKinley Sports Medicine for charges incurred by me for services rendered regardless of insurance benefits. I am aware that failure make payment on my account may result in legal or collection action to recover unpaid amounts and may include legal fees, court costs, and other charges as necessary. This authorization shall expire upon written notice.

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| Signature | Print Name | Date |
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