Carolina Hand & Sports Medicine, P.A. (CHASM)
Financial and Insurance Policy

Thank you for choosing Carolina Hand and Sports Medicine, P.A. as your health care provider. We are committed to building a successful physician-patient relationship. Your clear understanding of our financial/insurance policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions regarding this policy. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc). Failure to provide active insurance coverage information, will result in billing you directly for all services rendered.

- **SELF-PAY ACCOUNTS**: Full payment is due at the time of service unless other arrangements have been made in advance. For your convenience, we accept Cash, Check, MasterCard, Visa and Discover. Subject to approval, we also accept CARE CREDIT at no interest on 6 or 12 months plans.
- **INSURANCE CLAIMS**: Your insurance is an agreement between you and your insurance company. As a courtesy to you, we will file your insurance claims for the services rendered. You are required to pay any deductible, co-pay, and co-insurance as outlined in your policy at the time of service. You may receive a request for additional information or questionnaire form to be completed by you. If the requested information or form is not returned to your insurance company and/or we receive a denial on your claim, you will be responsible for payment in full. In the event your health plan determines a service to be "not covered", you will be responsible for the charge.
- **SURGICAL CLAIMS**: Our Financial Advisor will contact your insurance company to obtain surgical benefits. You are required to pay your deductible, and/or co-insurance prior to your surgery. Our charges are not included with the following and you may also receive a separate billing statement from the surgery facility, anesthesiologist, pathologist, and surgical implant company.
- **WORKER'S COMPENSATION**: If your injury is work related, verification of compensability is required from your employer. Our office will not file to your health insurance while compensability of injury is under investigation.
- **LIABILITY/MVA**: We do not do any third party billing. Our relationship is with you and not with the third party liability insurance (auto, homeowner, etc.) It is your responsibility to seek reimbursement from them. We do not accept LOP's (Letter of Protection) from attorney's. (Unless it is court ordered) The patient will be required to pay for all services rendered on the day of appointment and we will provide an itemized statement/receipt for you to collect your own reimbursement. Should you obtain an attorney, any outstanding balance will still remain your responsibility. Any unpaid balance while waiting for case to settle will be forwarded to collections if no payment has been made after 45 days of treatment regardless if you were instructed by your attorney not to pay.
- **MINOR/DIVORCED PARENTS:** The parent/legal guardian accompanying the child to the visit will be held responsible for all charges incurred regardless of the insurance or financial situation. We will not bill or discuss treatment with the other parent unless written authorization is on file. A written authorization for all minors being seen and treated is required from the parent/legal guardian.
- **FORMS/XRAYS:** A pre-payment of $25.00 is required for completion of the following: DISABILITY, FMLA, and ANY OTHER INSURANCE/MEDICAL FORM. There is a $5.00 charge for digital copy on disc for x-rays. (Advance notice of 24hrs is required)
- **RETURNED CHECKS**: In the event that a check is returned for insufficient funds, a NSF (non-sufficient fund) service charge of $25.00 will be applied to your account. We accept only cash or certified funds for the amount of returned check and balance owed.

- STATEMENTS/BALANCES/PAYMENT PLANS: Patient statements are sent weekly upon posting of your insurance plan's explanation of benefits. Payment in full is due upon receipt of a statement from our office within 30 days. Accounts become delinquent if no payment has been posted to your account within 45 days of receiving a statement. Failure to make full payment or calling our financial department to discuss payment arrangements will initiate collection proceedings after the 45 days.

- **Please be aware that CAROLINA HAND and SPORTS MEDICINE, P.A is an independent physician office (we are not part of MISSION) and we do not participate in any of the financial assistance programs you may qualify for with other medical facilities.**

Acceptance of financial responsibility: I understand that I am responsible for all medical expenses regardless of insurance coverage.
Authorization to treat and to release medical information: I hereby authorize medical treatment and the release of medical information requested from my insurance company as needed to process claims.
Authorization to pay: I hereby authorize payment directly from my insurance company to Carolina Hand and Sports Medicine, P.A.

Printed name of patient: _____

Patient/Legal Guardian/Guarantor signature: _____ Date: _____