

# Office Policies & Procedures

## CALIFORNIA PACIFIC ORTHOPAEDICS & SPORTS MEDICINE

California Pacific Orthopaedics & Sports Medicine does everything possible to minimize the cost of medical care. You can help a great deal by eliminating the need for us to bill you. In order to make our relationship work more effectively, the following is a summary of our payment policy.

### **Missed Appointments**

We will make every effort to accommodate your scheduling needs. In return we ask that you help us by keeping your scheduled appointments, and by notifying us in advance if you are unable to do so. All patients who fail to arrive for their scheduled appointments or who cancel with less than 24 hours advanced notice will be charged a missed appointment fee of **\$75.00**. This fee cannot be charged to your insurance carrier.

### **All payment is expected at the time of service**

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable co-insurance and co-payments for participating insurance companies. If our office must bill you for a co-payment, you will be charged a **\$15** administrative fee. This fee *cannot* be charged to your insurance carrier. CPOSM accepts cash, personal checks, Visa, MasterCard and Debit Cards. A **\$35.00** fee will apply on any returned check.

### **Outstanding Balance**

Patients with an outstanding balance must make arrangements for payment prior to scheduling appointments. We realize that people may have financial difficulty. Please communicate with our billing and collection staff so that they may assist to create a financial plan with you.

### **Copies of Records**

For copies of medical records, X-Ray and/or MRI, an advance payment of **\$25.00** is required. This fee *cannot* be charged to your insurance carrier.

### **Disability Forms**

For completion of all insurance disability forms other than California State Disability and Worker's Compensation forms, an advance payment of **\$20.00** is required. This fee cannot be charged to your insurance carrier.

### **Billing Questions / Refunds**

If you need any assistance or have questions, please call our billing department between 8:00 am and 4:30 pm, Monday through Friday at (415) 751-4610. Overpayments will be refunded upon written request within 30 days of our office confirmation.

### **Medication Refills**

For all medication refills, please call your pharmacy directly. We are unable to access patient records on evenings and weekends. Accordingly, narcotic refills cannot be honored during these times.

### **Insurance**

CPOSM will bill participating insurance companies as a courtesy; however, I understand that I am responsible for all charges not covered by my medical insurance policy including, but not limited to, co-payments, deductibles, co-insurance and non-covered services. I also agree to complete all necessary paperwork in order for my claim to be paid by my insurance company and accept full liability for all charges if payment is not made in my behalf by my insurance company.

**Surgery Cancellation Policy**

All patients who fail to arrive for their scheduled surgery or who cancel with less than 48 hours advanced notice will be charged a non-refundable administration fee up to **\$500**. This fee cannot be charged to your insurance carrier. If your primary care physician has not cleared you for surgery prior to this time, please contact your surgery coordinator as soon as possible.

In addition, all patients that cancel and re-schedule a procedure two (2) or more times will be charged a non-refundable deposit of **\$500** for each occurrence. This fee cannot be charged to your insurance carrier.

**Assignment of Benefits & Treatment Authorization**

I authorize the release of any medical or other information necessary to determine benefits or the benefits payable for related equipment or services to California Pacific Orthopaedics and Sports Medicine (CPOSM), my insurance carrier or other medical entity. A copy of this authorization will be sent to my insurance company or other entity if requested. The original authorization will be kept on file by CPOSM.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify CPOSM of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by CPOSM and/or my health care insurer if the submitted claims or any part of them are denied for payment.

**Notice of Privacy Practices**

The misuse of Personal Health Information has been identified as a national problem. We want you to know that all our employees, managers and physicians continually undergo training so that they understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act of 1996 (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of Personal Health Information in accordance with the governmental rules, laws and regulations. As part of this plan, we have implemented a Compliance Program that oversees the prevention of any inappropriate use of Personal Health Information.

I have read and understand the policies as out lines above. I understand that by signing this form I am accepting financial responsibility as explained for all payment for products received. I understand my financial responsibility as a patient.

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_  
**Today's Date**

\_\_\_\_\_  
**Signature of Patient/Legal Guardian**

\_\_\_\_\_  
**Relationship**

\_\_\_\_\_  
**Patient Name (print)**

\_\_\_\_\_  
**Today's Date**