## Patient Privacy Notice & Payment Policy

**Advanced Orthopaedic Associates, PA** **Patient Name:**
**2778 North Webb Rd. Wichita, KS 67226** **Date of Birth:**
**316-631-1600 - www.aoaortho.com** **MR#:**
**Account#:**
**Billing Dept: 316-631-1699** **Appt. Date:**

**Financial Responsibility-** All Payments are due at time of service. We accept cash, checks, debit cards, MasterCard, Visa, Discover. We accept Blue Cross, Medicare, Work Comp, most HMO's and PPO's and many insurance networks. We participate in the *Healthier You for Medicare ACO*.**We do not take Out of State or Federal work comp.** Please confirm your insurance network before your visit. If we do not participate in your insurance, payment is due at time of service. Co-pays must be paid at time of service or your visit will be rescheduled. If you have not met your deductible, payment is due at time of service. If we estimated your payment, any remaining balance will be billed or overpayment refunded. Your bill might include office visits, x-rays, surgeon fees, assistant surgeon fees (PA, APRN, etc), DME, orthotics, casting, or other charges. We are willing to make short-term payment arrangements. Accounts should be fully paid within 1 year to avoid an annual $50 rebilling fee. 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. Disability form preparation is $10.

**What if I don't have insurance (Self Pay)-** Self-pay patients must pay **$175** at your 1st visit; **$100** is due at subsequent visits unless arrangements are made. You will be billed for any balance due or refunded any overpayment. Self-pay surgery patients must make at least 50% payment **(minimum $500)** and sign a payment agreement for any balance when surgery is scheduled. Self-pay guidelines apply if you have auto insurance coverage but no other medical insurance. Self-pay guidelines apply 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 my insurance requires a referral-** You must obtain any required referral from your PCP or employer. This is common in HMO's and some other plans. 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. You should confirm any required surgical authorizations.

**What if my insurance does not pay-** As a courtesy, we file your insurance. You are responsible for providing accurate insurance information. Our relationship is with YOU, not your insurance. Please call your insurance if your bill is not paid promptly. By Kansas law, insurance claims should be paid within 30 days (KSA 40-2442). Failure to follow-up/respond to your insurance company requests for information will result in the balance 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. Cell phone communication and/or text messages may be utilized/requested for visit reminders and non-marketing phone calls made by or on behalf of AOA by our business 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. 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

[ Subject to change without notice.