Credit and Financial Policy

INSURANCE & PRIVATE PAY OVERVIEW

PREFERRED PROVIDER PLANS:
With certain insurance companies, it is necessary for you to be treated by a preferred provider to ensure the best coverage of your services. If the doctor is not on the preferred provider panel, you will be responsible for allowed and non-allowed charges. Please check with the registrar for a complete listing of preferred providers or contact your insurance carrier directly. A current copy of your insurance card is required.

MULTIPLE PLAN COVERAGE (COORDINATION OF BENEFITS):
As a courtesy, Rebound Orthopedics & Neurosurgery will bill your primary, secondary, and tertiary insurances. However, it is your responsibility to notify us of the proper order of coverage, including verifying that your insurance plans are aware of the multiple insurances. You must coordinate your benefits with them. If you do not notify us of the proper order and the insurance denies your claim(s), you will be responsible for all charges incurred.

MEDICARE: We accept assignment with Medicare. Rebound Orthopedics & Neurosurgery will also bill Medicare secondary as a courtesy for you.

MEDICAID:
Rebound Orthopedics & Neurosurgery requires a copy of the coupon at each visit. If we cannot confirm eligibility or if we do not have a referral at the time of the appointment, you will be asked to reschedule or pay a deposit and sign a waiver stating you will be responsible for all charges incurred during your visit.

NON-CONTRACTED PLANS and/or MOTOR VEHICLE CLAIMS:
Rebound Orthopedics & Neurosurgery will submit one insurance claim per visit as a courtesy, provided that a current insurance card is presented at your visit or we have proof of your personal injury coverage.

- *At your first visit,* a deposit of $250.00 is required for non-contracted plans and motor vehicle claims, which will be applied to any outstanding residual balance or refunded if appropriate after charges have been processed.

THIRD PARTY CLAIMS: Rebound Orthopedics & Neurosurgery does not bill third party claims.

HMO INSURANCE PLANS:
A referral is required from your primary care physician prior to each appointment and procedure. If we do not have a referral at the time of the appointment, you will be asked to reschedule or sign a waiver stating you will be responsible for all charges incurred during your visit.

WORKERS' COMPENSATION:
It is your responsibility to inform the registrar that the visit is for a work-related injury. This is to your benefit so that we bill appropriately. If the claim is DENIED or CLOSED or if you fail to inform Rebound Orthopedics & Neurosurgery of the work-related nature of your medical problem, including appropriate claim information, you will be responsible for all charges.

PRIVATE PAY:
Please speak with a financial counselor prior to your visit in order to establish a payment agreement. Rebound Orthopedics & Neurosurgery partners with health financing companies to help with payment for your visits, procedures, and surgeries. If you have not spoken to a financial counselor, please do so prior to your visit.

- *A $250 deposit is required prior to the New Visit to Rebound Orthopedics & Neurosurgery if you pay by cash, check, or credit/debit card.* On the day of your first appointment, you will pay for the remainder of the charges at the end of your visit.
- If you pay with cash, the new patient deposit is collected prior to the start of your first visit, and the remainder is collected at the end of your visit.
- *At each visit, payment is due in full at the end of your visit.* We will collect cash, charge to a credit/debit card, or add the charges to your medical loan if you have one set up.

A Division of Northwest Surgical Specialists, P.C.
200 NE Mother Joseph Place, Suite 210, Vancouver, WA 98664
Phone: (360) 254-6161
Fax: (360) 449-1146
www.reboundmd.com

rebound
ORTHOPEDICS & NEUROSURGERY
The Region's Most Preferred.

FORMS OF PAYMENT

CASH/CHECK	Cash, check, and money orders are accepted. There will be a $36.00 fee charged for returned checks.
CREDIT CARDS	Visa, Mastercard, American Express, and Discover are accepted for debit and credit. The card must be in the user's name.
CARECREDIT	We partner with CareCredit, a healthcare financing company offering extended balance carrying.
HEALTHFIRST	We partner with HealthFirst Financial, a healthcare financing company offering extended balance carrying.

PATIENT RESPONSIBILITY & STATEMENTS

It is your responsibility to know the type of insurance benefits and coverage under your plan. Responsibility for payment of your account remains with you at all times; and although you may have an insurance claim pending, we must look to you for payment regardless of the circumstances involved.

CO-PAY Copayment is due at the time of service.
Co-Pay: a flat rate applied to office visits and/or procedures and determined by your health plan.

DEDUCTIBLE & COINSURANCE This is a contract between you and your insurance plan. If you have a coinsurance and/or a deductible balance, Rebound Orthopedics & Neurosurgery will send you a statement after your claim has been processed with the insurance, and you will be required to pay this balance in full to Rebound Orthopedics & Neurosurgery within 60 days of your statement, or a payment agreement must be made within 60 days.

Deductible: the amount you must pay out of pocket to your provider before your insurance will begin to pay for your claims. This is outlined in your insurance plan.
Coinsurance: a percentage amount for which you are responsible for per visit or procedure. This is outlined in your insurance plan.

- You will receive a monthly statement showing itemized charges and the total amount due on your account.
- No credit will be extended to patients having a delinquent account or who have been referred to a collection agency for payment.
- *PAYMENT IN FULL IS REQUIRED WITHIN 60 DAYS OF THE DATE ON YOUR STATEMENT. IF YOU ARE UNABLE TO MAKE PAYMENT IN FULL WITHIN THE 60-DAY PERIOD, YOU MUST NOTIFY REBOUND ORTHOPEDICS & NEUROSURGERY PRIOR TO THE 60-DAY PERIOD TO SET UP A PAYMENT AGREEMENT.*

DURABLE MEDICAL EQUIPMENT:
During your visit, medical products may be recommended and/or dispensed to assist you with the healing process. In some instances, you will be required to pay cash at the time of your visit for non-covered DME. For covered items, Rebound Orthopedics & Neurosurgery will bill your insurance as a courtesy; however, you will be responsible to pay for any amount not covered by your insurance.

SURGERY:
In the event you require surgery or a procedure, a presurgical deposit will be required to be paid prior to scheduling. This deposit will be applied to your surgical or procedural private pay residual balance. An out-of-pocket cost estimate will be provided to you prior to scheduling your procedure.

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Acknowledgment of the Financial Policy, Waiver, Privacy Practices, and Assignment of Benefits
Northwest Surgical Specialists, P.C., DBA Rebound Orthopedics & Neurosurgery

I hereby agree to have the insurance benefits (payments) for my visits sent directly to Northwest Surgical Specialists, P.C. I understand that I am financially responsible for any and all charges incurred that my insurance may not cover at the time of this visit and future visits, including and not limited to lab, radiology, procedures, surgeries, and durable medical equipment. I hereby authorize release of essential information to such insurance companies to establish my claim. I am additionally responsible for follow-up billing and issues with my insurance company unless otherwise instructed by the clinic.

_____ I understand my insurance company will not be billed without a current copy of my insurance card.

_____ I understand that NSS/Rebound Orthopedics & Neurosurgery has not received authorization from my primary care physician. (For referral-based insurances only.)

_____ I understand that NSS/Rebound Orthopedics & Neurosurgery is not contracted with my insurance carrier.

_____I have received a copy of the Notice of Privacy Practices. (Separate copy is provided.)

_____I have received and agree to the Northwest Surgical Specialists, P.C., Credit and Financial Policy in its entirety. (Separate copy is provided.)

_____	_____	_____
Signature of Patient or Parent or Legal Guardian	Relationship to Patient	Date

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