SHENANDOAH VALLEY ORTHOPEDICS & SPORTS MEDICINE
FINANCIAL PAYMENT POLICY

The purpose of this form is for you to provide consent for treatment and agreement to our office fee and billing policies.

REGARDING INSURANCE: Our office participates with Medicare and many managed care insurance companies. Should your insurance coverage be with one or more of these companies, we will bill your insurance company along the guidelines of our contract. However, co-payments, co-insurances, deductibles, and non-covered services that have not been satisfied, are the responsibility of the patient and payment is expected at the time services are rendered. If you have an insurance with which we do not participate, we ask that payment be made at the time services are rendered and your insurance company will reimburse to you any amount due. As a courtesy to our patients, we will submit a claim to your insurance company.

SPECIAL NEEDS: It may be necessary to set up a payment plan for a patient who cannot comply with our financial policy. If you are in need of special payment arrangements, please advise our staff prior to your visit. **Co-pays are exempt from this because your insurance requires you to pay your co-pay at the time services are rendered.** You are required at the time we see you to notify us if this is a worker's compensation or accident visit to avoid additional financial costs. If you are not covered by any insurance, let us know you are self-pay and ask us about our same day discount.

I authorize treatment by the providers of Shenandoah Valley Orthopedics & Sports Medicine. I authorize the release of any information requested by insurance companies or liable third parties and I assign any insurance benefits or injury benefits to Shenandoah Valley Orthopedics & Sports Medicine. If the correct insurance information is not given to Shenandoah Valley Orthopedics or the proper referral is not obtained, then the patient will be responsible for the bill.

I acknowledge that I upon request, I may obtain a copy of a separate document, entitled "Notice of Privacy Practices" which sets forth Shenandoah Valley Orthopedics & Sports Medicine privacy practices and my rights regarding privacy of my protected health information.

EXPOSURE PROVISION: If a health care provider or any employee of Shenandoah Valley Orthopedics & Sports Medicine is directly exposed to my blood or other body fluids in a manner (such as through an accidental needle stick) which may transmit HIV, Hepatitis or other blood borne pathogen, I hereby consent to be tested for above viruses. I understand that Positive results will also be disclosed as medically necessary in connection with medical treatment or as required or permitted by law.

I hereby understand the financial policy of this office. I agree, in order for Shenandoah Valley Orthopedics & Sports Medicine to service my account or to collect any amounts I may owe, they may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. They may also contact me by sending text messages or emails using any email address I provide to them. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I have read this disclosure and agree that their collection agency may contact me/us as described above. I guarantee payment of all charges incurred for the account of the below patient. I further agree to pay 25% Attorney's fee, 35% Valley Credit Service fee, 6% Judgment Interest, Court Costs, and related collection fees incurred on my account. I hereby waive the benefit of my homestead exemption as to this debt. I also agree my employer may be contacted to verify employment status.

- **A $50.00 FEE WILL BE CHARGED FOR NO SHOWS**
- **A $25.00 FEE WILL BE CHARGED PER FORM. EXAMPLE: FMLA OR DISABILITY**
- **A $35.00 FEE WILL BE CHARGED FOR A RETURNED CHECK**
- **CO-PAYS ARE DUE IN FULL ON DATE OF SERVICE, OR YOU WILL BE RESCHEDULED.**
- **YOU ARE RESPONSIBLE FOR OBTAINING A REFERRAL IF REQUIRED BY YOUR INSURANCE COMPANY**
- **INSURANCE INFORMATION SUBMITTED TO US PAST THE TIMELY FILING DATE, WILL BE YOUR FULL FINANCIAL RESPONSIBILITY**
- **YOUR RECORDS WILL BE KEPT FOR 7 YEARS FROM YOUR LAST DATE OF SERVICE**

_____ _____ _____/_____/_____

Patient or Guardian Signature **Print Patient/Guardian Name** **Date**

(Must be 18 or older to sign).

Please let us know if you would like a copy of our Financial Policy for your records

Edited 12/8/2020