PAYMENT POLICY

1. Ortho Montana accepts the following types of payments: Visa, Master Card, American Express, Discover, Cash, Check, or Money Order.

2. Non-insured patients will be expected to pay at least $100 at the time of service and set up a payment plan for the balance with the Business Office at the first appointment.

3. Deductible, co-insurance, and any non-covered services are the responsibility of the patient. To the extent possible and feasible, all patient financial responsibilities are payable at the time of service and /or prior to surgical procedures.

4. For outstanding patient balances, Ortho Montana requires a payment plan to be set up with the Business Office.

5. Office co-pays are required at the time of service as stipulated by your health insurance company.

6. As a courtesy, Ortho Montana will file all claims with primary and secondary insurance carriers plus Medicare, Medicaid and Workers Compensation. Please provide the office with a copy of all insurance card(s). We grant sixty (60) days for the insurance to pay; however, any balances pending insurance or non-covered by insurance are the obligation of the responsible party. Payments received may be applied to any outstanding charges on the account.

7. Workers Compensation claims will be filed; however, denied claim or claims pending over 90 days will be the responsibility of the patient. Payment arrangements may be made with the Business Office.

8. A compound finance charge equal to the maximum allowed by federal regulations will be levied against the unpaid balance of accounts that are sixty (60) days old or older. Your account may be forwarded to an outside collection agency for further action if regular payments are not made or there is no payment activity in 75 days. When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check transaction or bank draft drawn from your account. Any checks returned for non-sufficient funds may be charged a returned check fee of $30 as allowed by state law.

9. Ortho Montana recommends that you contact your insurance company regarding any pre-certification requirements for services. Examples: MRI, Therapy, Surgery, etc.

10. For minor children, the parent that accompanies the minor child to the appointment will be listed as the responsible party and guarantor for the minor child's charges.

11. I understand that I may make payments on the Ortho Montana website at www.montanabones.com.

12. Ortho Montana is committed to providing the best treatment possible for our patients at rates that are usual and customary for our area. Responsible parties are obligated for payment in full regardless of the interpretation of what is usual and customary by a given insurance company.

13. Failure to honor your financial obligation to Ortho Montana in accordance with this signed Agreement will result in your account being referred to Collections and termination of the treatment relationship in accordance with regulations that govern ethical medical care. All fees and /or costs related to collection of your account will be applied. (i.e. agency fees, court costs, attorney fees, etc.)

14. I have read and understand this payment policy and agree with the conditions of this payment policy as indicated by signing below.

Patient's Legal Name: ______________________________ Patient#: ____________________

Responsible Party's Signature: __________________________________ Date: _______________