Tri-Valley Orthopedic Financial Policy

NAME OF PATIENT: ______________________________ **D.O.B.** ______________

COPAYMENTS: Copayments are required at the time of service.
A $25.00 charge for non-payment at time of service can take place if copay not made.

HIGH DEDUCTIBLE PLAN:
Deposit Required – New patient Deposit of $100.00 required for all High Deductible ($1,000.00 or higher) and Non-Contracted plans.
Established Patient Deposit of $50.00 required for all High Deductible ($1,000.00 or higher) and Non-Contracted insurance plans. Cash or Credit

SURGERY: If future care includes surgical intervention, we will verify your insurance benefits. Your estimated co-insurance will be collected prior to your surgery date and will be applied to any outstanding residual balance. You will receive separate bills from providers outside of TVO such as the surgical facility, anesthesiologist, lab, cardiologist, assistants in surgery, etc.

MEDICAL RECORDS: Medical records $25.00 due at time of Request. 7-14 Day turnaround from time of request received.
X-ray or MRI CD $15.00 due at time of request. 7-14 Day turnaround from time of request received. (In house MRI/ X-ray will receive a onetime courtesy CD)

FORMS: State Disability forms are $25.00 for initial and $15.00 for each extension form. All other Private Disability Forms are $15.00 for each form. DMV Parking Placard $15.00. Payment for all forms is required prior to completion.

CREDIT CARDS ACCEPTED: Visa, Master Card, Discover or American Express.

PATIENT BILLING STATEMENTS: You will receive a monthly statement showing itemized charges and the total due on your account. Payment in full is required within 30 days. A Finance Charge of 1.5% will be assessed on residual balances 60 days and older. Payment plan is available upon request. There will be a $25.00 fee for returned checks.

NO SHOW POLICY: $25.00 no-show charge assessed for appointments that are not cancelled within a 24-hour period prior to the appointment, will be charged to your card on file or account immediately.

LIMITATION OF OUR RESPONSIBLITY: TVO makes no promises and is not responsible in any way financially for any non-covered benefits and does not guarantee or take responsibility for in or out of network status related to your health plan. This includes but is not limited to any labs, test, procedures, referrals, consultations or any other medically related services that are recommended, ordered or submitted by this or any medical office. I understand if claims are denied due to eligibility status, an invalid medical group, invalid Primary Care Physician or any other reason, I will assume full responsibility for all charges incurred by myself and my dependents. Additionally, I will be financially responsible for any non-covered benefits, deductibles and copays at the time of service.

SELF PAY/ NO- INSURANCE: Full payment is due at the time of service; we accept Cash or Credit card only.

SECONDARY INSURANCE/ THIRD PARTY CLAIMS (Motor Vehicle Accidents): We will only bill secondary insurance claims once as a courtesy. We do not bill third party claims or accept third party insurance claims.

INSURANCE PLANS: It is your responsibility to notify us of any changes with your insurance, including any referrals or authorizations. Failure to provide this information will prevent accurate billing to your insurance carrier, thus, making you responsible for payment in full.

DURABLE MEDICAL EQUIPMENT: We do not accept returns for any Durable Medical Equipment/Orthotics for any reason. DME braces/orthotics may not be covered by your insurance.

WORKER'S COMPENSATION: It is your responsibility to inform the front desk at the time of visit if you are here for a work-related injury. If the claim is DENIED, CLOSED or if you fail to inform us of the work-related nature of your medical problem, including appropriate claim information, you will be responsible for all charges.

My signature below indicates that I have read, understood and agreed to the Financial Policy of Tri-Valley Orthopedic Specialists, INC.

______________________________ ______________________________
Patient / Legal Guardian Signature Print Patient Name

______________________________ ______________________________
Print Name / Of Legal Guardian Date

ASSIGNMENT OF BENEFITS – FINANCIAL AGREEMENT

I hereby give authorization for payment of insurance benefits to be made directly to Tri-Valley Orthopedic Specialist, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. Refunds will be issued upon request.
I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is complete, my signature authorizes releasing of the information to the insurer of the agency shown.

In Medicare assigned cases, the physician/supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.
I hereby authorize this healthcare provider to release all necessary information to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature of Patient or Legal Representative: ______________________________

HIPAA Compliance

As mandated by the Federal Government and Office of Civil Rights, Tri-Valley Orthopedic Specialists is required to follow the **HIPAA Compliance Act to ensure patient confidentiality.** I understand that as part of my healthcare, Tri-Valley Orthopedic Specialists, Inc., maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care treatment.

I understand that this information serves as a 1) basis for planning my care and treatment; 2) means of communication amount the many healthcare professionals who contribute to my care; 3) source of information for applying my diagnosis and surgical information to my bill; 4) means by which a third-party can verify that services billed were actually provided; 5) a tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right: 1) to object to the use of my health information for directory purposes; 2) to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operation – and that the organization is not required to agree to the restrictions requested; 3) to revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Comments and Restrictions: ______________________________

\I authorize release of billing/medical information to: [ ] Parent [ ] Spouse [ ] Guardian [ ] Other

Name of authorized person(s) ______________________________

Detailed message regarding test results can be left on my answering machine: **[ ] Yes [ ] No**

______________________________ ______________________________
Signature of Patient or Legal Representative **Date**

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated**: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions**: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation**: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect**: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below.

Effective as of the date of first medical services: ______________________

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: ______________________

(Physician's Authorized Representative's Signature) (Date)

Patient or Patient Representative's (Date)

Tri-Valley Orthopedic Specialists, INC.

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(If Representative, Print Name & Relationship to Patient)