

We would like to thank you for choosing Tucson Orthopaedic Institute (TOI) as your healthcare provider. We are committed to providing you with the best possible orthopaedic medical care.

To reduce confusion and misunderstanding between our **patients** and practice, we have adopted the following **financial policies**

We are in-network for most, but not all insurance plans as well as government agencies including Medicare and Medicaid (AHCCCS); however, it is your responsibility to verify what your insurance plan covers for your healthcare needs and that Tucson Orthopaedic Institute (TOI) is considered an “In Network” provider by your insurance carrier. We encourage all patients to be familiar with their insurance benefits and how to access care to maximize coverage and minimize unnecessary out-of-pocket expenses.

For Our Patients with Medical Insurance Benefits

- ❖ **Proof of insurance**: All patients must complete our patient information form before seeing a provider. We must obtain a copy of your valid driver’s license and current, valid, insurance card. Your appointment will be rescheduled if you do not have these items available upon check in.
 - If you are covered by an insurance company that we are not contracted with, and wish to schedule with our providers, payment will be collected in full at the time of service. We will provide you with the information you need to file a claim directly with your insurance carrier for any reimbursement you may be allowed.
- ❖ **Referrals and Authorizations**: For those insurance carriers that we are contracted with, it is our policy to implement and follow the referral and prior authorization guidelines for services provided to you by these carriers
 - TOI will make every effort to inform you of your insurance requirements. However, it is ultimately your responsibility to know and understand what is required by the insurance plan. For specific information regarding orthopedic specialty care, you should contact the insurance customer service number printed on your insurance identification card.
 - When a referral/prior authorization is required, you must obtain such referral from your assigned Primary Care Physician (PCP) prior to your first appointment. If the authorization is not provided, you may be asked to reschedule until one is obtained.
 - Failure to follow insurance guidelines may result in you being financially responsible for all services rendered by our providers. Your insurance benefit is a contract between you and your insurance company and we make every effort to assist you in meeting the contractual obligations of your policy.
- ❖ **Co-pay, Coinsurance, Deductible**: Your insurance requires that we collect your designated co-pay and/or deductible at the time of service. Please be prepared to pay the above noted fees at each visit. *The practice will not waive, fail to collect, or discount co-payments, co-insurance, deductibles, or other patient financial responsibility in accordance with state and federal law, as well as participating agreements with carriers. **If you are unable to pay your co-pay at the time of service you may be required to reschedule your appointment.***
- ❖ **Medicare**: Medicare covers 80% of allowable charges; you will be responsible for the remaining 20% plus any applicable deductible. Non-covered medical charges are also your responsibility. You will be notified of those services not covered by Medicare and you will be allowed to decline those services. In these circumstances, you will be asked to sign an Advanced Beneficiary Notice (ABN) that describes the service the doctor is recommending that may not be covered by Medicare along with the cost of that service.

- ❖ **Medicare Replacement plans:** Many patients that qualify for Medicare have chosen to sign up for Medicare Replacement Plans. If you have one of these plans, you do **NOT** have Medicare. Please ensure you know your benefits and your responsibilities based on the plan you have selected. These plans typically have co-pays that will be collected during check-in.
- ❖ **Non-covered services:** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. Payment for these services will be required at the time of your visit.
- ❖ **Coverage changes:** If your insurance changes, please notify us before your next visit. This will allow us to update your file and confirm eligibility prior to your appointment.
- ❖ **Claims submission:** As a courtesy, we will submit your claims and assist you in any way we reasonably can to get your claims paid. Your insurance company may need you to supply certain information directly. We appreciate you supplying this information to the carrier as timely as possible to avoid being billed the balance of your unpaid claim.
- ❖ **Secondary Insurance:** Having more than one insurer DOES NOT always mean that your services are covered at 100%. We will bill your secondary carrier as a courtesy, but any remaining balances, once the insurances have cleared, will be billed to you directly.

For Our Patients without Medical Insurance

- ❖ If you do not have group or individual medical insurance, payment for all professional services is expected at the time of service. We take cash, credit cards and care credit. If a payment arrangement is needed, an appointment with one of our financial counselors will be required prior to scheduling for services. All payment arrangements are made on a case-by-case basis and based on individual need and financial ability.

Motor Vehicle Accidents (MVA) and Third Party Liability Insurance

- ❖ **Auto Accident:** If your injury is a result of an auto accident, you are required to pay for services before treatment from our physicians/providers. We will provide you with receipts to provide to your auto carrier for reimbursement.
- ❖ **Liability Injury:** If your injury is the result of another party's negligence, you are required to pay for services before treatment from our providers. We will provide you with receipts so you can collect directly from the responsible party.
- ❖ We do not extend discounts for third-party insurance or MVA insured claims.

Workers' Compensation/Employment Related Injuries

- ❖ You are required to notify our office in advance that you will be seeing our providers under a worker's compensation claim in order to allow TOI the opportunity to authorize payment for treatment. A valid case/claim number and insurance information must be provided by you at the time of appointment scheduling. **We do not accept out of state worker's compensation claims.**
- ❖ **We are unable to schedule patient appointments under any of the following circumstances:**
 - There is no prior approval from the worker's compensation insurance or employer. A valid case/claim number and insurance coverage information must be provided at time of scheduling.
 - The worker's compensation claim is being disputed or denied
 - The patient is in process of filing a worker's compensation claim
 - The patient is considering filing a worker's compensation claim
- ❖ If a worker's compensation carrier denies further authorization for patients already undergoing treatment, it will then be the patient's responsibility to contact their health insurance carrier and receive approval **in writing** for any further treatment.
- ❖ You will be required to have your entire CA-16 form if you are a patient that has US DOL.

Minor Patients and Custodial Parent Responsibilities

- ❖ A minor child (anyone under the age of 18 years and non-emancipated), must be accompanied by a custodial adult to receive health care services. The legal guardian of an unaccompanied minor must make prior arrangements with the practice to allow for non-accompanied visits, and the authorization

must be in writing and presented at the scheduled appointment time. Unaccompanied minors will not be treated for non-emergency services.

- ❖ The parent(s) (or guardians of the minor) are responsible for full payment. The responsibility for payment remains that of the parent/guardian whose signature is on file at time of visit.
- ❖ Minor children coming of age (reaching the age of 18, will be required to update their paperwork on file with the practice. Guarantor ship will transfer to the adult child unless the custodial adult signs the updated paperwork accepting the obligation of guarantor for services provided.

Medical Records and Miscellaneous Services

- ❖ The fees noted below will be collected prior to the processing and release of the requested information.
- ❖ **Medical Records Requests:** Please allow 5-7 business days to process all requests for medical records. Medical records will be provided at a cost of \$6.50 per chart (paper), or \$5 on CD. We encourage you to sign up for the Tucson Orthopaedic Patient Portal (Follow My Health-FMH) to have continuous access to your medical record free of charge.
- ❖ **Disability/FMLA Forms:** Please allow 5-7 business days to process. There will be a one-time fee of \$25.00 per specific injury/episode of care being documented.
- ❖ **X-Ray/Radiology Requests:** We will provide all radiology records on a disk free of charge for continuum of care purposes. All other requests will incur a fee of \$5.00 for each disk produced.

What to Expect from Us:

- ❖ Collection of all balances related to your services, including co-pays, deductibles, coinsurance, non-covered service fees, etc. at the time of your visit.
- ❖ Accepted forms of payment:
 - **Cash/Check** -Cash, personal checks and money orders.
 - Post dated checks are not accepted
 - You will be charged a \$25.00 fee for checks that are returned for non-sufficient funds. Returned checks must be redeemed with cash or credit card within 14 days of being returned or you may be turned over to the Pima County Attorney's Office.
 - **Credit Cards/HSA Cards**-Visa, MasterCard, American Express, and Discover or valid health savings account debit/credit card.
 - **Care Credit/Health First Financial** -We partner with Care Credit. Please ask us if you would like more information regarding this credit services.
 - **Payment Plans** – Provided on a case-by-case basis after meeting with a TOI financial counselor.
- ❖ **Billing statements and invoices:** As a courtesy, Tucson Orthopaedic Institute will process and submit claims to your insurance company on your behalf. We will also send you an itemized billing statement listing each service and associated charge you have been billed for.
 - Upon receipt of payment from your insurance, any services, or portion of services not covered by your insurance plan will be billed to you. This includes an unsatisfied deductible and any out-of-pocket expenses not covered by your carrier.
 - Payment is due within 15-days of receipt.
 - Your account is considered past-due thirty (30) days from the date of the first statement.
 - You will receive a maximum of 3 statements (Initial, Past Due, and Final Notice).
 - If your account balance is 45-days past due, or more, you will not be allowed to schedule an appointment with the practice until your account balance is satisfied.
 - If your account is over 90-days past due and you do not have an approved/authorized payment arrangement, or have not honored your payment arrangement, your account may be turned over to a collection agency, inclusive of the fees charged by the agency for collection purposes.
 - Failure to pay unpaid balances can result in the termination of your care with the practice.
- ❖ **Surgeries and other Outpatient Procedures:** As part of the scheduling process for surgeries, your insurance company will be contacted to verify coverage, your preadmission requirements, and to obtain

authorization for the procedure. When possible, we will verify any coinsurance, unmet deductible amounts, and your unmet out-of-pocket limits. This information will be used to create an *Estimate of Patient Responsibility* based on your insurance benefits. You will be contacted by our financial counselors regarding your financial requirements prior to your surgery. If you have any concerns and would like to contact our financial counselors directly you can reach them at (520) 784-6265.

- These are only **ESTIMATES** and can change depending on changes in coverage, unmet deductibles, or if additional procedures need to be performed based on medical necessity. Payment arrangements will be expected prior to your surgical date, and delay in making arrangements could cause your surgical case to be rescheduled.
- Should your payment exceed the cost of service, a refund will be issued to you upon final review and closure of your claim.
- *Please note that the authorization received by us from your insurance carrier is not a guarantee of payment. Remember, it is your responsibility to understand your coverage and to verify what your insurance plan will pay as well and if TOI or its Physician is a network provider of your plan. We cannot guarantee that your insurance carrier will pay all or even part of your claim. Please be aware that the balance of your claim is your responsibility. We encourage you to work with us during the process by speaking directly with your insurance plan administrator to fully understand all limitations and obligations under your contracted coverage. If an insurance billing problem occurs, you may be asked to assist us in contacting your carrier.*

- ❖ **Fracture Care Disclosure:** Insurance companies require we bill our services using a coding system known as Current Procedural Terminology (CPT). Codes for fracture care treatment are located in the “surgery” section of the CPT codebook and identify the exact fracture and the care plan rendered. The term “surgery” does not imply an operation was performed; this is merely the format in which CPT is organized for ease of use by both the insurance companies and providers.
 - In the event you are diagnosed with a fracture, even when there is no manipulation needed in treating the fracture, it is still considered fracture care.
 - Fracture care is a **single** charge which includes 90 days for follow up treatment, also known as the global period. Each time you visit the provider during the global period of your treatment plan you will not be charged for the office visit. However, there may be charges for any x-rays, casting, bracing, splinting or injections (etc) required during those visits.
 - With many insurance, coverage for these services apply to deductible and will be billed to you and are due within 30 days of initial billing.