

Today's Date: \_\_\_\_\_ Co-Pay: \_\_\_\_\_

**PLEASE COMPLETE THIS FORM IN ITS ENTIRETY**

How did you learn about our practice? \_\_\_\_\_

Patients Name: \_\_\_\_\_  
Last First Middle

Patients Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

SSN: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_ May we correspond with you by email? Yes No

Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Preferred Pharmacy: \_\_\_\_\_

**PLEASE PROVIDE THE RECEPTIONIST WITH CURRENT INSURANCE CARDS AND DRIVERS LICENSE**

Primary Insurance Plan: \_\_\_\_\_ Secondary Insurance Plan: \_\_\_\_\_

Plan ID#: \_\_\_\_\_ Plan ID#: \_\_\_\_\_

Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_ Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_

**FINANCIALLY RESPONSIBLE PARTY (SUBSCRIBER FOR INSURANCE IF OTHER THAN PATIENT)**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Last First Middle

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

How did your injury occur? \_\_\_\_\_

On what date did the injury occur? \_\_\_\_\_ Where did it happen: \_\_\_\_\_

Did your injury happen on the job? Yes No If yes, did you report the accident to your employer? Yes No

Family Physician: \_\_\_\_\_ Drug Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Major Illnesses: \_\_\_\_\_

In case of emergency, contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work or Cell Phone: (\_\_\_\_) \_\_\_\_\_

**Signature of Patient or Responsible Party:** \_\_\_\_\_

**PLEASE TURN THIS SHEET OVER AND COMPLETE THE FINANCIAL INFORMATION**

# Financial Policies

Thank you for choosing St. Charles Orthopaedic Surgery Associates, Inc. (SCOSA) for your orthopaedic care. We are committed to the success of your medical treatment and care. Please understand that payment of your bills is part of this treatment and care.

**Referrals** If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office you may use the telephone available to call your primary care physician to obtain it. If you are unable to obtain the referral at that time you will be rescheduled.

## Your Financial Responsibilities

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts. We accept payment by cash, check, Visa and MasterCard. **Payments can be made electronically via our website, [www.scosamd.com](http://www.scosamd.com).** You will receive statements from our office for account balances that are your responsibility, the balance is due within 15 business days. If the patient portion of your account is not paid in a timely manner collection efforts will be made. Any collection agency fees incurred to collect the patient portion of your account will be at your expense.

**HMO, POS and PPO plans that SCOSA contracts with:** If the services you receive are covered by the plan and you have provided any required referral and/or authorization, you are responsible for all applicable copays and deductibles, these are to be paid at the time of service. If the services you receive are not covered by the plan payment in full is requested at the time of service.

**Commercial Insurance or PPO's that SCOSA does NOT contract with:** SCOSA will submit your claims to your carrier as a courtesy if all current and accurate information is provided. You will be billed for any remaining balance with the total amount due within 15 days of billing.

**Medicare:** You will be responsible for any portion of your deductible that is not paid or covered by your secondary. You will be responsible for any service not covered by Medicare. If you do not have secondary insurance you will be responsible for the 20% copay. SCOSA will submit Medicare and secondary claims. All patient balances remaining after Medicare and secondary payment will be billed to you and will be due within 15 days of billing by this office.

**Medicaid:** SCOSA physicians are not participating providers in Missouri Medicaid. Payment is required at the time of service. We will work with you to arrange a payment plan. This will be determined on a case by case basis. Please request an APPLICATION FOR SELF-PAY PATIENT DISCOUNT form.

**Workers Compensation:** If we have verified the claim with your workers comp carrier no payment is necessary. If we are not able to verify your claim payment in full is required at the time of service.

**No Insurance:** Payment in full is required at the time of service. If you have financial hardships we will work with you to arrange a payment plan. This will be determined on a case by case basis. Please request a copy of our SELF-PAY POLICY and an APPLICATION FOR SELF-PAY PATIENT DISCOUNT form.

*I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copays and deductibles, are my responsibility.*

*I authorize my insurance benefits be paid directly to St. Charles Orthopaedic Surgery Associates, Inc. (SCOSA)*

*I authorize SCOSA to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.*

---

**Signature of Patient or Responsible Party**

---

**Date**