

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: _____ Birth date: _____ Age: _____ Sex: M F

Home Phone: (____) _____ Cell Phone: (____) _____

Email address: _____

Occupation: _____ Employer: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Work Phone: (____) _____ Ext: _____ Pharmacy Location: _____

Race: _____ Language: _____ Ethnicity: Hispanic Non-Hispanic Decline to Answer

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 (SIGNER OF FINANCIAL POLICY IF NOT THE 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

Primary/Family Physician: _____ Drug Allergies: _____

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 orthopedic 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 we are contracted with, you need a referral from your primary care physician authorizing this treatment. If we have not received the 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 for your visit, you may be rescheduled or required to fill out and sign our "Visit with No Referral" form which makes the patient financially responsible for all charges incurred at your visit.

Your Financial Responsibilities:

Our office will file insurance for all reimbursable services, to 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, MasterCard and Discover.

Payments can be made electronically via our website, www.scosamd.com.

You will receive billing statement(s) from our office for account balances that are your responsibility, balance in full 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 do not accept new patients with Missouri Medicaid.

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. It is your responsibility to report your work comp injury to your employer and to inform us that your injury is the result of a work comp injury.

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