THE CAMALIER BUILDING, SUITE 506 · 10215 FERNWOOD ROAD · BETHESDA, MD 20817 · TEL (301) 530-1010 · FAX (301) 897-8597

OrthoBethesda Therapy Services
Patient Financial Policy & Consent to Treatment

We are committed to providing you with the best possible care, and will help you receive your maximum allowable insurance benefits. We need *your* assistance and *your* understanding of our payment policy. Your insurance contract is between you, your employer and the insurance company. Not all services are covered by all contracts. While the filing of insurance claims for participating insurance carriers is a contractual obligation of the practice, all fees are ultimately the patient's responsibility. We will be happy to help you process your insurance claim form for reimbursement. For Medicare assignment and participating insurance plans, covered charges will be paid directly to us. **We file to participating secondary payers one time only**. If payment is not received within 45 days, we will send you a statement and payment will be expected at that time. This office cannot accept responsibility for negotiating a settlement on a disputed claim. If we do not participate in your insurance plan, you may still choose to be seen by the practice. We will require payment in full at the time services are rendered. As a courtesy to you, we will provide you with the documentation necessary for you to file with your insurance carrier on your own behalf.

Medicare Patients receiving Therapy Services: A reimbursement cap of $2010 is in effect for 2018 therapy claims filed with Medicare. There are exceptions provided for certain diagnoses, however. You may request assistance from our staff if you think you may be approaching your cap or you qualify for an exception. Once you have met the therapy cap for the year, you will be responsible for paying for the uncovered services.

We will estimate and collect patient balances, including co-payments, co-insurance and deductibles, on the day of the visit but will wait for the claim to be processed by the insurance plan, as applicable, before collecting the full amount due. Required insurance referral forms must be complete, current and presented at time of service. If you arrive for your appointment without valid, current insurance identification or a required referral, we will offer you the option of rescheduling your visit or making payment in full at the time services are rendered. All patients are encouraged to submit photo identification at the time of registration to enable our office to reduce the incidence of identity theft. We accept cash or checks, Visa, MasterCard, Discover or American Express. A fee of $35.00 will be charged for checks returned for insufficient funds or any other reason, whether issued directly by the patient or on the patient's behalf. An additional monthly fee will be charged on all past due accounts. Fees (which are generally not covered by insurance plans) will be charged for services such as copying of medical records and x-rays and the completion of insurance/physical forms. **We require 24-hours notice (one full business day) if you wish to change or cancel your appointment. A $35 charge may be assessed for appointments missed without this notice. Patients who cancel or fail to show for three appointments will be discharged from the practice.** We encourage you to contact us promptly for assistance in the management of your account. We are here to help you and will be happy to answer any questions you may have about your treatment or insurance coverage.

By signing below you are agreeing to the terms above, as they are written and without modifications, and are providing Bethesda-Chevy Chase Orthopaedic Associates, L.L.P. ("OrthoBethesda") and OrthoTraumaBethesda, L.L.P. consent to provide medical treatment.

X_____ _____

Signature of Patient, Policy Holder or Legal Guardian Date

Acknowledgement of Notice of our Privacy Practices: A copy of our privacy policy is available for you in our waiting room. By signing below, you acknowledge that you have been given the opportunity to receive a copy or review the policy.

X_____ _____

Signature of Patient, Policy Holder or Legal Guardian Date

Ortho Bethesda
RESTORING FUNCTION

WASHINGTON Joint Institute at OrthoBethesda

Ortho Trauma BETHESDA

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