

For the Finest Orthopedic Care

www.atlasortho.net



ATLAS ORTHOPEDICS
AND SPORTS MEDICINE

7975 Lake Underhill Rd.,
Suite 330,
Orlando FL. 32822

P. 407-381-8441
F. 407-381-8557

PATIENT FINANCIAL POLICY

PAYMENT INFORMATION: Our fees for services, including office visits, surgeries, and procedures are based on the level of professional skill required; the severity and complexity of the injury or illness, as well as the time spent treating you. Please do not hesitate to inquire about the charges for our services; however a precise estimate in advance may not be possible.

UNINSURED INFORMATION: Payment in full at the time services are rendered.

MINOR PATIENTS: The adult accompanying the minor is responsible for payment.

INSURANCE INFORMATION: As a courtesy to you, we will bill your insurance company. Insurance companies sometimes use the phrase “usual and customary” when discussing professional and facility fees. The insurance companies set their own “usual and customary” rates based on a wide geographical area and the fees we charge may differ. You will be billed for any applicable **co-payments**, and/or **deductibles**, and/or **exclusions** of your insurance contract. We encourage our patients to contact their insurance company prior to any appointment, surgery, procedure, or diagnostic study (C.T. scan, MRI, etc.) to verify eligibility, coverage, and preauthorization requirements.

We ask that you realize that services are rendered to a person, not an insurance company. Hence, the insurance company is responsible to the patient and the patient is responsible to us. If we do not participate with your insurance company you will be billed for all charges they deem over “reasonable and customary”.

We are “participating providers” with the insurance companies: LISTED ON THE INSURANCE PARTICIPATION LIST.

MOTOR VEHICLE INSURANCE OR WORKERS COMPENSATION: Our billing office will also file your workers’ compensation and motor vehicle claims. You are required to provide the following information: **Insurance carrier and address, Date of Injury, Claim number, Employer at time of accident (work comp only), and Adjustor and contact number.** This information will ensure accurate and timely filing of your claims, without this information we be unable to submit your claim to your work comp or motor vehicle carrier and, therefore, will ask you for payment in full at time of service. If your claim is denied or not paid within a timely manner we request that you file a personal claim with your health insurance or pay the charges in full.

SURGERY AND PROCEDURES: We require **pre-payment** of any deductible and co-payment amounts for private pay insurance. This payment is based on information we will receive from your insurance company and our estimated charges. This payment is required prior to your surgery or procedure.

Please Note:

If you are unable to meet our payment requirements, our billing department will be happy to discuss this with you.

We accept the following forms of payment: Cash, Checks, Visa, MasterCard, and Discover.

If it becomes necessary to send your account to collections for non-payment, you will be responsible for all collection and legal fees incurred.

By signing, I am indicating that I have read and understand the above policies, and had all my questions answered.

Patient or Guarantor Signature

Date