Edmonds Orthopedic Center
Financial Policy

Edmonds Orthopedic Center (EOC) is committed to providing you with the best possible medical care. The following information outlines financial responsibilities related to payment for professional services.

Financial Responsibility

You, the patient, are ultimately responsible for all charges associated with your care regardless of insurance coverage.

Participating Insurances

EOC participates with a variety of insurance plans. It is your responsibility to:

Bring your insurance card and picture ID to every visit.

Be prepared to pay your co-pay before each visit. Payment can be made by cash, check, or credit card.

For medical care not covered under insurance, payment will be your full responsibility.

Non-Participating Insurances

If you have insurance that the office does not participate in, our Business Office will file a claim as a courtesy. However, if payment from a secondary carrier is not received within 60 days of filing, all charges will become patient responsibility and immediately due and payable.

Medicare

EOC is a participating provider with Medicare. We always file your primary claim. We will file secondary carriers as a courtesy only. If payment from a secondary carrier is not received within 60 days of filing, all charges will become patient responsibility and immediately due and payable.

Motor Vehicle Accidents

We will file auto carriers as a courtesy only, and will require confirmation of medical insurance coverage. If we do not receive confirmation of medical insurance coverage, we expect a $300 cash or credit card payment to secure your first appointment, and a $150 payment for all subsequent visits. If you fail to keep your appointments or cancel with less than 2 business days notice, you will be charged this non-refundable payment. Any balance is your responsibility and must be paid at the time of the visit. Likewise, any associated surgery or ancillary services will require a 100% prepayment.

Other Prepayments

We require a $300 prepayment toward services rendered for any other third party payor.

Patients With No Insurance

We expect a $300 cash or credit card payment to secure your first appointment, and a $150 payment for all subsequent visits. If you fail to keep your appointments or cancel with less than 2 business days notice, you will be charged this non-refundable payment. Any balance is your responsibility and must be paid at the time of the visit. Likewise, any associated surgery or ancillary services will require a 100% prepayment. Be aware we offer a cash discount to patients who pay in full at the time of service.

Referrals
It is your responsibility to bring any required referral for treatment at or prior to your visit. If you do not have your referral, your visit may be rescheduled or you may be financially responsible for the services provided.

Treatment of a Minor
If the patient is a minor (18 years and younger), the parent or guardian must sign below. The parent, guardian, or unaccompanied minor is responsible for any payment due at the time of service, required referrals, insurance and picture ID cards.

Additional Charges
For checks returned for Not sufficient Funds, a $25 fee will be charged to your account.

Payment Arrangements
Payment arrangements can be arranged if needed. Please contact the Business Office to discuss terms.

Collection Agency and Bad Debt
It is a federal guideline that we cannot book any type of appointment for you if your account has been turned over to collections or has a bad debt write-off. You must clean up any amounts due either with EOC or our outside collection agency prior to booking any type of follow up appointment.

If you have questions about your insurance, our Business Office will help you. However, specific coverage issues should be directed to your insurance company member services department (number is on the insurance card).

Edmonds Orthopedic Center believes that a good physician/patient relationship is based on understanding and communication. Your signature below indicates that you have read and agree to this Financial Policy.

________________________________ ________________

Signature of Patient or Responsible Party Date

________________________________ ________________

Signature of Co-Responsible Party Date