



Coastal Orthopedics & SPORTS MEDICINE

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Richmond Hill, GA 31324
T: (912) 756-3599, F: (912) 756-5397

Christopher M. Vaughn, M.D., Brodie E. McKoy, M.D., Crystal K. Cotrell,

Patient Name _____

It is our office policy to inform you of our patient payment procedure. Please review the section below that is applicable to you and number (7) (General Acknowledgement).

Financial Policy

____ 1. **Patient With Insurance:** You are responsible for deductibles, copays, noncovered services, coinsurance and items considered “not medically necessary” by your insurance company. Please pay co-payments and coinsurance amounts as services are rendered. The remaining balance should be taken care of within one (1) month of notice from insurance company. If you or your insurance carrier makes payment exceeding your balance, reimbursement will be remitted. If payment cannot be made at each visit, notify the front-desk staff to make other arrangements prior to being seen.

____ 2. **Worker’s Compensation Patient:** As a Worker’s Compensation patient you may be covered by insurance if your injury is reported at work and verified with your employer. Be sure to inform the office personnel that your injury resulted during employment. Patient is ultimately responsible for balance.

____ 3. **Personal Injury (Accident):** If you are a personal-injury patient, our office does not bill “3d Party” insurance claims. All charges for the services rendered will be your responsibility and are expected as services are provided.

____ 4. **Medicare:** Our office will submit your Medicare charges to Medicare and your secondary insurance. You are responsible for deductibles, copays, and any noncovered services.

____ 5. **Insurance we do not participate with:** We will file with your insurance for you. You are responsible for deductibles, co-pays, non-covered services, coinsurance and items considered “not medically necessary” or out of network by your insurance company. Please make co-payments and deductibles for your care at each patient visit. If cash, check, or normal credit card payment cannot be made at each visit, our office participates with CareCredit Inc. Please see paragraph six below for further information about CareCredit. If payment arrangements cannot be finalized we will inform you how to locate an “in-network” provider.

____ 6. **Patient Without Insurance (Self Pay):** Please make payment for your care at each patient visit. If cash, check, or normal credit card payment cannot be made at each visit, our office participates with CareCredit Inc. If you have an existing CareCredit account we will process your incurred charges through them. If you do not have a CareCredit account we will assist you in applying for this service. The service allows you to apply for no interest credit plans for up to eighteen months or low interest extended payment plans of twenty-four to sixty months. The front-desk staff will provide you with additional information and assist you in completing a CareCredit application. The result for your application must be known prior to your visit. Individual payment arrangements can only be considered when requested by one of our healthcare providers.

____ 7. **General Acknowledgement:** I understand that if my account has a balance I will be billed monthly for the balance. If a financial arrangement is approved for me, I will still receive a statement for the balance of my account. Failure to keep my account current by meeting the terms above, or of the financial agreement (if approved), will result in my account being assessed a fee of the greater, \$5 or 5% of the balance, each month I fail to meet the terms.

ASSIGNMENT

____ I request that payment of authorized Medicare benefits be made either to me or on my behalf to Coastal Orthopaedics and Sports Medicine for any service furnished me by that provider. Medicare Number _____

____ The signature below authorizes payment of mandated Medigap benefits to Coastal Orthopaedics and Sports Medicine. Medigap _____ Policy Number _____ Group Number _____

____ I assign the benefits from my insurance carrier(s) to this clinic for the medical/surgical benefits I am entitled to.

RELEASE OF INFORMATION

____ I authorize Coastal Orthopaedics and Sports Medicine to release to my insurance carrier(s) and/or CMS (formerly HCFA) and its agents and/or my Medigap insurer any information, including Protected Health Information, as needed to determine benefits or benefits payable for related services.

I have read and agree to the Financial Policy, Assignment, and Release of Information paragraphs stated above that apply to me.

Patient or responsible party signature Date

Person signing on behalf of patient (print name) Reason patient can't sign

Relationship to Patient Address Phone

Financial Arrangement Statement

__ I have an approved CareCredit account. I authorize Coastal Orthopaedics and Sports Medicine to add charges to my CareCredit account as they are accumulated for my family member or myself.

__ Being disapproved for CareCredit, I agree to make ____ payments. At a minimum, payments will be made monthly in the amount of \$_____. If payment is unable to be made, I will call patient accounts at 877-3235 to inform them and discuss next payment. I understand my account will be assessed a fee each month I fail to meet this agreement as described on the reverse.

__ I authorize Coastal Orthopaedics and Sports Medicine to charge my credit card monthly on or about the 1st or 15th in the amount of \$_____ (or less for remaining balance) for dates of service from ___/___/___ to ___/___/___.

Cardholder signature Date

<u>Patient Name</u> _____		
<u>Cardholder Name</u> _____		
<u>Cardholder Address</u> _____		
<u>City</u> _____	<u>State</u> _____	<u>ZIP</u> _____
<input type="checkbox"/> Visa	<input type="checkbox"/> MasterCard	<input type="checkbox"/> Discover <input type="checkbox"/> American Express
<u>Credit Card Number</u> _____		<u>Expiration Date</u> _____

I have read and agree to the financial policy stated above that applies to me and to the financial arrangements as outlined on this form.

Patient or responsible party signature Date

Person signing on behalf of patient (print name) Reason patient can't sign

Relationship to patient Address Phone
