CHARLOTTESVILLE HAND SURGERY, PLC
320 WINDING RIVER LANE, SUITE 303
CHARLOTTESVILLE, VA 22911

FINANCIAL POLICY

As a courtesy to its patients, Charlottesville Hand Surgery will file insurance claims upon receipt of a current insurance card. If coverage is denied, I will be billed and payment in full is due upon receipt. I will also be responsible for all co-pays, deductibles, and balances due following insurance payments.

It is my responsibility, with the help of Charlottesville Hand Surgery, to ensure that all referrals/authorizations are obtained prior to medical care. If the referral/authorization is not obtained and my claim is denied, I will be responsible for the balance. I agree that there will be a charge for disability and other insurance forms that require Charlottesville Hand Surgery providers to complete.

In the event that my account, following insurance payments and the normal billing cycle of Charlottesville Hand Surgery, is not paid in full within ninety days of date of service, I agree that I will be responsible for collection fees of thirty-three percent and court costs. I will also be responsible for interest of eighteen percent as of date of service. I agree that elective procedures will be paid for prior to the procedure except for any applicable health insurance.

I agree that there will be a fifty dollar fee for failing to show for a scheduled appointment and a sixty dollar fee for a returned check. There will be no penalty for a first missed appointment. We require 24 hours notice when cancelling an appointment to avoid the fifty dollar fee. Extenuating circumstances are taken into consideration. There will be a twenty dollar fee for failing to pay co-pay at the time of office visit.

I authorize my employer to release all information regarding my employment. I agree that Charlottesville Hand Surgery may discuss all financial aspects of my account with my spouse or family member listed on my account.

I have read the above and understand the Financial Policy of Charlottesville Hand Surgery, PLC.

PATIENT NAME (IF UNDER THE AGE OF 18) _____

PRINT NAME_____ _____
Date

SIGNATURE_____ _____
Relationship (if under 18)

MEDIGAP AUTHORIZATION

(All Medicare Secondary policy patients and others with secondary insurance)

I authorize any holder of medical or other information about me to release to Medigap payor or other secondary insurance, as listed in my chart, any information needed for this or a related Medigap or other insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to Charlottesville Hand Surgery, PLC who accepts assignment.

_____ _____
Signature of Patient and/or Legal Guardian **Date**