

*Douglas S. Skura, M.D.*

*Mark Stover, D.O., FAOAO*

Patient: \_\_\_\_\_

## **FINANCIAL POLICY AND AGREEMENT**

Thank you for choosing us as your health care provider. We are committed to providing you with the best possible medical care. Please understand payment of your bill is considered a part of your treatment. The following information is provided to avoid any misunderstanding or disagreement concerning payment for services, tests, and supplies provided by our office.

1. Our office participates with a variety of insurance plans. It is your responsibility to:
  - a. Bring your current insurance card to every visit and notify us of changes in coverage.
  - b. Be prepared to pay your co-pay, coinsurance and/or deductible at each visit. Payment can be made by cash, check, MasterCard or Visa. If you don't receive a bill, you understand that it is your responsibility to pay the amount that is due.
  - c. We will submit a claim to your insurance company for you. Balances not paid, per our contract by your primary insurance company may be billed to your secondary payer. A statement will be sent to you. Ultimately you are responsible for payment of services and for any out amount above what was collected at time of service.
  - d. Be prepared to pay any outstanding balance plus your co-pay, coinsurance, and/or deductible at check-in for each visit. Payment can be made by cash, check, MasterCard or Visa.
  - e. You understand that your insurance carrier can choose to assign benefits to Memorial Hospital of Union County d/b/a Marysville Orthopedics or your insurance carrier may make payment directly to you.
  - f. You understand and certify that you are financially responsible for all health care service charges that are paid to you directly by your insurance carrier, as well as for any applicable co-payment, co-insurance, deductible or charges for non-covered services provided to you or any of your dependents.
2. If you do not have insurance coverage or if you are insured by a company with which we are not contracted, payment in full is expected at time of service unless payment arrangements are made and kept.
3. If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company member services department (phone number should be on your insurance card).
4. This office charges for all services that are significant and separately identifiable. Patients that are seen for physical exams and require other treatments for illnesses or problems may be charged separately for each service even when both are provided on the same day.
5. This office can only code and file a claim for a patient's visit with a diagnosis that was encountered and documented in the medical record. To request a diagnosis change solely for the purpose of securing reimbursement from the insurance carrier is inappropriate and could be considered a fraudulent act.
6. All balances billed are due within 30 days of the statement date. Unpaid balances greater than 30 days are subject to our collection process. Accounts sent to our collection agency are subject to a collection charge of \$50.00 for balances up to \$150.00 and for balances of \$150.01 and higher the fee is 35% of the outstanding balance.



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7. There will be a \$25.00 fee charged for all appointments that were not kept and/or not cancelled at least 24 hours prior to the appointment time.
8. There is a \$25.00 fee on all returned checks.
9. For medical record requests made by the patient or the patient's personal representative, the charge is tallied accordingly: Pages 1-10, \$2.74 per page; Pages 11-50, \$0.57 per page; Pages 51 & up, \$0.23 per page. Actual cost of any related postage to be incurred will also be added to the fee to copy any or all medical records. The fee for medical records will be waived if the records are to be used for continuation of care and sent directly to the provider's office.
10. For medical record requests made by someone other than the patient or the patient's personal representative, there is a \$16.84 fee for all records searches, then charge is tallied accordingly: Pages 1-10, \$1.11 per page; Pages 11-50, \$0.57 per page; Pages 51 & up, \$0.23 per page. Actual cost of any related postage to be incurred will also be added to the fee to copy any or all medical records. The fee for medical records will be waived if the records are to be used for continuation of care and sent directly to the provider's office.
11. There is a sliding fee for FMLA and/or Disability forms. This is a form fee to be paid prior to the forms completion, and is charged as follows: \$25.00 for 7 business days turn-around; \$50.00 for 3 business days turn-around.
12. If you cancel, miss, or no show for three (3) appointments you may be dismissed from the practice for not complying with the plan of care you & your physician have discussed.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

By signing below, you certify that you will pay Memorial Hospital of Union County d/b/a Marysville Orthopedics any co-payments, co-insurance, deductibles or non-covered services. You will immediately pay to Memorial Hospital of Union County d/b/a Marysville Orthopedics any payments that you receive from your insurance company for services provided to you or your dependents. You will also be responsible for any amounts not paid by insurance because you have not provided the appropriate insurance information for billing.

You understand and agree that if your account is delinquent, Memorial Hospital of Union County d/b/a Marysville Orthopedics may deny you or your dependent, as named above, further supplies and services or may require that you pay for supplies and services at the time of the visit.

You certify that the information you have provided is a true and complete statement according to your best knowledge and belief, and that a full explanation of services and charges has been given to you. You understand that if you give false information, withhold information or fail to report changes promptly, you will be breaking the law and can be prosecuted and/or have services discontinued.

\_\_\_\_\_  
PRINT PATIENT'S NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PATIENT OR GUARDIAN

\_\_\_\_\_  
OFFICE STAFF WITNESS