Patient Information & Policies

Thank you for choosing Midwest Orthopaedic Institute, PC (MOI) as your healthcare provider. Please read and acknowledge the following information and policies prior to receiving treatment. We are happy to discuss any questions you have regarding your treatment, fees, and services.

_____**Consent to Treat:** I hereby authorize and consent to the performance of examinations, diagnostic procedures, treatments which my physician and I agree are necessary. I understand that no guarantee has been made as to the results of the care, treatment, and/or medications given to me.

_____**Underage Patient Policy:** It is the policy of MOI and its physicians that no one under the age of 18 will be evaluated if they present to the office alone. For initial evaluations, patients under the age of 18 are required to have a parent or legal guardian accompany them to the initial office visit. Should the underage patient's parent/guardian not be able to attend the follow up visit, the patient will only be seen/treated with a signed Underage / Minor Patient Authorization For Treatment Form.

_____**Patient Financial Responsibility:** I understand that, as a courtesy to me, MOI will submit charges related to my care to my primary and secondary insurance carriers. It is my responsibility to resolve any questions regarding coverage, benefits, or payment for services provided. I am financially responsible for any covered or non-covered services which are not paid by my primary or secondary insurance. I understand that any unpaid charges over 60 days old will be my responsibility, plus a processing fee of 1% of the outstanding balance per month. My account may be submitted to small claims court if I fail to pay my bill or have not made acceptable payment arrangements. MOI may place MY delinquent account with a collection agency and I am responsible for all processing fees. In addition, I will be responsible for all court costs, filing fees and attorney fees should this account require litigation.

If your payment by check is returned to us for nonsufficient funds you will be charged a $50.00 returned-check fee. You must then pay with cash, cashier's check or credit card in the amount of the outstanding check plus the $50.00 service fee.

_____I hereby assign to MOI payments made by my insurance company.

_____I authorize MOI to verify employment with my employer in accordance with Federal law.

_____**No Health Insurance Coverage:** We expect payment at the time of service for patients without health insurance coverage. A $250.00 deposit fee is required before you are treated and any remaining balance, due to you or from you, will be reconciled after your visit.

_____**Workers Compensation:** MOI will bill my worker's compensation insurance or my employer providing prior authorization. If my claim gets denied MOI will bill my health insurance and any remaining balance will be my responsibility.

_____**Injuries and Accidents:** MOI will bill the third party carrier, providing prior authorization. If my claim get denied or benefits become exhausted MOI will bill my health insurance and any remaining balance will be my responsibility. I understand that any unpaid charges over 60 days old will be considered my responsibility.

_____**No-Show Policy:** If you are unable to keep your scheduled appointment, please cancel at least 24 hours prior to that appointment. If MOI is closed, please leave a voicemail for the receptionist. A no-show fee of $30.00 will be charged if you miss your scheduled appointment. A no-show fee of $150.00 will be charged if you miss your scheduled procedure appointment, MRI appointment or complex visit appointment. If you arrive later than 15 minutes after your scheduled appointment, you may be asked to reschedule in order to accommodate patients who have arrived on time.

_____I prefer to receive my statement via email. **Email address:** _____

_____Please do not email my statement. I prefer to receive my statement via standard mail.

PATIENT NAME _____ DATE OF BIRTH _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE _____ RELATIONSHIP IF NOT PATIENT _____ DATE _____