Carolina Hand & Sports Medicine, P.A. (CHASM)
Financial and Insurance Policy

We believe it is our goal to establish a financial policy to reduce confusion and misunderstanding between our patients and the office. We are dedicated to providing the best possible care to you and regard your complete understanding of our financial policies as an essential element of your care and treatment. Please understand that payment of your bill is part of this treatment and care. It is the patient's responsibility to provide our office with the correct insurance information. Failure to provide this information, will result in billing you directly for all services rendered. We highly recommend that you READ YOUR INSURANCE BOOKLET to determine and understand your benefits. Please contact one of our patient account representatives should you have any questions.

- **SELF-PAY ACCOUNTS**: Full payment is due at the time of service unless other arrangements have been made in advance. For your convenience, we accept Cash, Check, MasterCard, Visa and Discover credit cards. Subject to approval, we also accept CARE CREDIT at no interest charged if payment is made in full within 6 months.
- **INSURANCE CLAIMS**: Your insurance is an agreement between you and your insurance company. As a courtesy to you, we will file your insurance claims for the services rendered. You are required to pay any deductible, co-pay, and co-insurance as outlined in your policy at the time of service. You will be responsible for promptly responding to your insurance company to provide any additional information they may request regarding your treatment, pre-existing conditions, accidents or other insurance coverage. Failure to respond in a timely manner can result in your account becoming due and payable, in full, immediately. In the event your health plan determines a service to be "not covered", you will be responsible for the charge.
- **SURGICAL CLAIMS**: You are required to pay your deductible, and/or co-insurance prior to your surgery as per your surgical benefits. Our charges are not included with the following and you may also receive a separate billing statement from the surgery facility, anesthesiologist, pathologist, and surgical implant company.
- **WORKER'S COMPENSATION**: If your injury is work related, verification of compensability is required from your employer. If the injury is denied, all charges incurred will be your responsibility. Our office will not file to your health insurance while compensability of injury is under investigation.
- **LIABILITY/MVA**: We do not file to third party of any motor vehicle insurance nor do we accept LOP's (Letter of Protection) from attorney's. (Unless it is court ordered) The patient will be responsible for all services rendered and we will provide an itemized statement/receipt for you to collect your own reimbursement. Should you obtain an attorney, the balance still remains your responsibility. Any unpaid balance while waiting for case to settle will be forwarded to collections.
- **MINOR/DIVORCED PARENTS:** The parent/legal guardian accompanying the child to the visit will be held responsible for all charges incurred regardless of the insurance or financial situation. We will not bill or discuss treatment with the other parent unless written authorization is on file. A written authorization for all minors being seen and treated is required from the parent/legal guardian.
- **FORMS/XRAYS:** A pre-payment of $25.00 is required for completion of the following: DISABILITY, FMLA, and ANY OTHER INSURANCE/MEDICAL FORM. There is a $5.00 charge for digital copy on disc for x-rays. (Advance notice of 24hrs is required)
- **RETURNED CHECKS**: In the event that a check is returned for insufficient funds, all charges incurred by CHASM shall be your responsibility. A service charge of $50.00 will be applied to all returned checks. We accept only cash or certified funds for the amount of returned check and balance owed.

- **STATEMENTS/BALANCES/PAYMENT PLANS:** Patient balances are billed immediately on receipt of insurance plan's explanation of benefits. Payment in full is due upon receipt of a statement from our office within 30 days. Failure to make full payment or calling our financial department to discuss payment arrangements will result in collection proceedings. In the event the amount due cannot be paid in full, we offer interest free payment plans for 3,6,9,12 months depending on balance due. After 12 months, an interest charge at the rate of 1.5% per month (18% per annum) will be added based on the accrual amount for each month over 12 months of the payment plan.

- **Please be aware that CAROLINA HAND and SPORTS MEDICINE, P.A does not participate in any of the financial assistance programs you may qualify for with other medical facilities.**

Acceptance of financial responsibility: I understand that I am responsible for all medical expenses regardless of insurance coverage
Authorization to treat and to release medical information: I hereby authorize medical treatment and the release of medical information requested from my insurance company as needed to process claims
Authorization to pay: I hereby authorize payment directly from my insurance company to Carolina Hand and Sports Medicine, P.A.

Printed name of patient: _____

Patient/Legal Guardian/Guarantor signature: _____ Date: _____