

ORTHOTIC SOLUTIONS FINANCIAL POLICY

Patient Name _____ Date _____

Insurance Authorization and Assignment of Benefits

It is important to realize that many insurance companies do not cover the full amount of our charges or they may not cover them at all. Understand that nothing is a guarantee of payment until the claim is submitted to your insurance company and responsibility for payment rests directly with you. Orthotic Solutions is not responsible for benefits quoted by any insurance company.

Note: If you are a VA Medicaid patient, you must be under 21 years of age in order for Medicaid to pay for our services.

Payment of Account

While filing of insurance claims is a courtesy we extend to all of our patients; all charges are your responsibility. Your payment is due in full at the time of casting unless other arrangements have been made. If you provided us with complete insurance information we will submit a claim directly to your insurance company for processing once the device is delivered. If the charges are under \$100 a claim will not be submitted unless we participate with your insurance. If financial planning is necessary, we encourage you to contact us promptly for assistance in the management of your account.

Refunds: Once Orthotic Solutions has cast and/or measured for a custom orthosis a minimum of 20% of the total charges are non-refundable. In addition, any fabrication or modification expenses incurred prior to cancellation of the orthosis will be added to the non-refundable amount.

To the best of my knowledge all the information provided to this office is complete and accurate. I acknowledge that ALL charges incurred in this office are my responsibility. If my insurance, for any reason, fails to pay for any charges billed, I agree to pay for services upon notification by a representative of this office. I understand that if my account remains unpaid for a period of 90 days, it may be referred to an attorney for collection. I further agree to be responsible and pay for all costs incurred, including 33.3% attorney's fees (minimum of \$50.00) and interest at 1.5% per month (18% per annum). I also authorize Orthotic Solutions to release any medical information requested by my insurance company and/or physician to process this claim. I request that payment of authorized insurance benefits be made either to me or on my behalf to Orthotic Solutions for any services furnished to me by Orthotic Solutions.

Please note that both Guardians must sign below, if applicable:

Signature _____ Date _____
Patient or Authorized Representative

Signature _____ Date _____
Patient or Authorized Representative

