Orthotic Solutions

Patient Name: _____ Date:_____

Financial Policy

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; the responsibility of payment rests directly with you. Orthotic Solutions is not responsible for benefits quoted by any insurance company and you are responsible for all non-covered services under your insurance plan.

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 $100.00, 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 casted 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 the 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 a 33.3% attorney's fees (minimum of $50.00) and interest at 1.5% per month (18% per annum). I also authorize Orthotic Solution 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.

Note: You will be charged a $50.00 fee for all No-Show/Canceled appointments with less than 24 hours' notice.
*** If you are a Virginia Medicaid Patient, please note you must be under the age of 21 in order to have this service paid for by the state.**

Signature _____ Date _____
Patient or Authorized Representative

If signing for a Patient over the age of 18: print name and address, relationship to patient, reason why patient can't sign.