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X. NICK LIU, DO
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PATIENT PAYMENT POLICY

THANK YOU FOR CHOOSING OUR PRACTICE! WE ARE COMMITTED TO THE SUCCESS OF YOUR MEDICAL TREATMENT AND CARE. PLEASE UNDERSTAND THAT PAYMENT OF YOUR BILL IS PART OF THIS TREATMENT AND CARE. FOR YOUR CONVENIENCE, WE HAVE ANSWERED A VARIETY OF COMMONLY-ASKED FINANCIAL POLICY QUESTIONS BELOW. IF YOU NEED FURTHER INFORMATION ABOUT ANY OF THESE POLICIES, PLEASE ASK TO SPEAK WITH A BILLING REPRESENTATIVE OR THE PRACTICE MANAGER.

HOW MAY I PAY?
WE ACCEPT PAYMENT BY CASH, CHECK, AND ATM OR CREDIT CARD WITH A VISA OR MASTERCARD LOGO.

DO I NEED A REFERRAL?
IF YOU HAVE AN HMO PLAN WITH WHICH WE ARE CONTRACTED, YOU NEED A REFERRAL AUTHORIZATION FROM YOUR PRIMARY CARE PHYSICIAN. IF WE HAVE NOT RECEIVED AN AUTHORIZATION PRIOR TO YOUR ARRIVAL AT THE OFFICE, WE HAVE A TELEPHONE AVAILABLE FOR YOU TO CALL YOUR PRIMARY CARE PHYSICIAN TO OBTAIN IT. *IF YOU ARE UNABLE TO OBTAIN THE REFERRAL AT THAT TIME, YOU WILL BE RESCHEDULED.*

WHICH PLANS DO YOU CONTRACT WITH?
PLEASE SEE ATTACHED LIST. YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ACCEPT ASSIGNMENT OF INSURANCE BENEFITS. *HOWEVER,* IT IS YOUR RESPONSIBILITY TO CALL YOUR INSURANCE COMPANY PRIOR TO YOUR FIRST OFFICE VISIT TO DETERMINE YOUR BENEFITS, YOUR CO-PAYMENT, DEDUCTIBLE OR IF YOU REQUIRE AN AUTHORIZATION TO SEE A SPECIALIST.

WHAT IS MY FINANCIAL RESPONSIBILITY FOR SERVICES?
YOUR FINANCIAL RESPONSIBILITY DEPENDS ON A VARIETY OF FACTORS, EXPLAINED ON THE FINANCIAL POLICY OVERVIEW, PLEASE ASK FRONT OFFICE STAFF FOR A COPY.

WHAT IF I REQUIRE FORMS TO BE FILLED OUT BY THE PHYSICIAN (FMLA, DISABILITY, INSURANCE COMPANY FORMS, DMV FORMS) WHAT IS THE PROCESS AND IS THERE A FEE?
WE CANNOT FILL IN FORMS "ON DEMAND". ALL FORMS WILL BE PROCESSED AND COMPLETED IN A 7 DAY PERIOD OF TIME. THE FEE FOR EACH FORM IS $30.00. PLEASE BE ADVISED THAT IF YOUR SHORT/LONG TERM DISABILITY PROVIDER IS NOT RESPONSIBLE FOR REPRODUCTION AND DELIVERY OF MEDICAL RECORDS, THEN PAYMENT REQUESTS WILL BE DIRECTED TO THE PATIENT. COPIES OF ANY IN HOUSE STUDIES WILL BE $30.00 EACH, THE FIRST PATIENT COPY WILL BE PROVIDED FREE OF CHARGE. **COMPLETED PAPERWORK MUST BE PICKED UP FROM OUR OFFICE. PAPERWORK CANNOT BE FAXED.**

WHAT IF I DO NOT HAVE INSURANCE?
PATIENTS WHO DO NOT HAVE INSURANCE ARE REQUIRED TO SPEAK TO MANAGEMENT PRIOR TO RECEIVING TREATMENT AND ON A CASE BY CASE BASIS WILL OFFER A PAYMENT STRUCTURE.

WHAT IS THE PROCEDURE IF I REQUIRE SURGERY?
IF YOUR PHYSICIAN RECOMMENDS SURGERY, YOU WILL BE ESCORTED TO HIS SURGERY COORDINATOR. SHE WILL ANSWER SPECIFIC QUESTIONS ABOUT THE SURGERY SCHEDULING PROCESS, DISCUSS THE PAPERWORK AND TESTS INVOLVED, AND COMPLETE ALL PRE-CERTIFICATION/AUTHORIZATION IF YOUR INSURANCE COMPANY REQUIRES IT. THE SURGERY COORDINATOR WILL REQUEST A PRE-SURGICAL DEPOSIT, THE AMOUNT OF WHICH DEPENDS ON YOUR COVERAGE AND DEDUCTIBLE AMOUNT. A COST ESTIMATE WHICH SHOWS YOUR FINANCIAL RESPONSIBILITY, BASED ON THE BENEFIT LEVELS AND COVERAGE OF YOUR INSURANCE PLAN, WILL BE EXPLAINED BY THE SURGERY COORDINATOR.

WHAT IF MY CHILD NEEDS TO SEE THE PHYSICIAN?
A PARENT OR LEGAL GUARDIAN MUST ACCOMPANY PATIENTS WHO ARE MINORS ON EACH PATIENT'S VISIT. THIS ACCOMPANYING ADULT IS RESPONSIBLE FOR PAYMENT OF THE ACCOUNT, ACCORDING TO THE POLICY OUTLINED ON THE PREVIOUS PAGES.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE FINANCIAL POLICY. I UNDERSTAND THAT CHARGES NOT COVERED BY MY INSURANCE COMPANY, AS WELL AS APPLICABLE COPAYMENTS AND DEDUCTIBLES ARE MY RESPONSIBILITY. I AGREE TO PAY FOR ALL ATTORNEY'S FEES, COURT COSTS AND FILING FEES, INCLUDING CHARGES THAT MAY BE ASSESSED BY OUR COLLECTION AGENCY TO PURSUE COLLECTION OF MY ACCOUNT. I AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO: ADVANCED ORTHOPEDICS AND SPORTS MEDICINE. I AUTHORIZE ADVANCED ORTHOPEDICS AND SPORTS MEDICINE TO RELEASE PERTINENT MEDICAL INFORMATION TO MY INSURANCE COMPANY WHEN REQUESTED, OR TO FACILITATE PAYMENT OF A CLAIM.

X_____ X_____ _____/_____/_____
SIGNATURE *PRINTED NAME* *DATE (MM/DD/YYYY)*

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ADVANCED ORTHOPEDICS & SPORTS MEDICINE

CASH PAYING PATIENT POLICY

TO OUR RESPECTED CASH PAYING PATIENTS, PLEASE BE ADVISED OF
THE FOLLOWING ESTIMATED AMOUNT FOR SERVICES RENDERED

INITIAL OFFICE CONSULTATION $254.00

ESTABLISH PATIENT FOLLOW UP VISIT $154.00

X-RAYS (PER BODY PART) $50.00

MRI EXTREMITY (I.E. SHOULDER, KNEE, ELBOW, ETC.) $350.00

MRI SPINE OR HIP(S) $400.00

FRACTURE CARE (REDUCTION IN-OFFICE) .....$1200.00 (APPROXIMATELY)

CORTISONE JOINT INJECTION $599.00

APPLICATION OF CAST .....$600.00-$700.00

PLASMA RICH PROTEIN (PRP) - PER INJECTION.....$600.00-$1000.00

PROLOTHERAPY - PER INJECTION $150.00

INJECTABLE MEDS (I.E. SYNVISC, EUFLEXXA, SUPARTZ) ..$750.00-1000.00

THE AFOREMENTIONED AMOUNTS ARE ONLY ESTIMATES AND ARE SUBJECT TO CHANGE BASED ON THE PHYSICIAN'S ASSESSMENT AND THE NATURE OF YOUR INJURY/ILLNESS. OUR OFFICE WILL BE ABLE TO DISCLOSE THE ACCURATE AMOUNT OF YOUR SERVICES AFTER YOUR VISIT WITH THE DOCTOR. IF SURGERY IS WARRANTED, QUOTES FOR THE PROCEDURE(S) WILL BE DISCUSSED AT THE TIME OF YOUR VISIT.

SHOULD YOU HAVE ANY QUESTIONS PRIOR TO OR FOLLOWING YOUR VISIT, PLEASE DO NOT HESITATE TO ASK OUR OFFICE STAFF.

THANK YOU,

ADVANCED ORTHOPEDICS
AND SPORTS MEDICINE

_____ _____
PATIENT SIGNATURE *DATE*