MSOC

Michigan SportsMedicine
and Orthopedic Center

www.michigansportsmedicine.com

- **John K. Anderson, MD**
- **John K. Morris, MD**

- Orthopedic Surgery
- Physical Therapy
- Sports Fitness

4972B West Clark Road
Suite 200
Ypsilanti, MI 48197
734.434.3020
734.434.3025 Fax

OFFICE POLICIES

We would appreciate you taking a moment to review our office policies listed below.

APPOINTMENTS

- Patients are seen on an appointment basis only. We try to maintain our daily schedule, however, being an Orthopedic practice emergencies frequently arise. We appreciate your patience and understanding
- Due to many changes in insurance coverage and federal regulation of identity verification, it will be necessary to present your insurance card and picture id at each appointment.
- If you are unable to keep your appointment, please cancel within 24 hour notice
- If you do not show for an appointment and do not call you may be charged a $25.00 no show fee
- If you are more than 15 minutes late for your appointment you may be asked to reschedule your appointment

PRESCRIPTIONS

- If you need a new prescription or a refill of your current medication, please allow the office (2) days to process your request. All prescription requests need to be verified by your physician before they are filled.

MEDICAL RECORDS

- We will complete one medical disability form per month at no charge to you. There will be a $10.00 fee for each additional form. Please allow 7-10 business days to complete disability forms. We also need a signed authorization by you to release any medical information to your employer.
- Due to new laws mandated by the US Government pertaining to the privacy of your health information we must have a signed authorization by your, along with the name, address and phone number of all parties you wish your medical records be released to.

I acknowledge that I read and/or received a copy of Michigan Sports Medicine and Orthopedic Center, P.C. Office Policies. I agree with the terms within.

Printed Name: _____ Date: _____

Signature _____

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OFFICE BILLING POLICY

Insurance copayments will be collected at the time of service. If you are unable to pay your copayment today, please reschedule your appointment. For your convenience, our office accepts personal checks, Visa, MasterCard, Discover, Cash and Care Credit.

Self pay (no insurance) patients must pay on the date of service. If we get a returned check our fee is $30.00.

All previous balances are due prior to your next appointment. After 3 statements are sent there will be a $5.00 monthly statement fee for each additional statement sent.

Our Finance charges will be charged at a rate of .5% monthly and 6% annually for unpaid bills over 90 days past due.

If after 90 days, we have not received payment from your insurance company; our office reserves the right to send the entire bill to the patient for payment. It will be your responsibility at that point to contact your insurance company with any questions or concerns regarding your bill.

Due to many changes to insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay on top of these changes, it is not always possible. **It is your responsibility to know the special terms, deductibles, and our copayments of your insurance coverage. Failure to notify us will result in non-covered expenses which will be your responsibility.**

If your insurance requires you to have a written referral or authorization such as an HMO, Workers Compensation or Auto Insurance it is the responsibility of the patient to obtain it PRIOR to the appointment. If you do not have the referral, you may need to reschedule your appointment or you will be responsible for the charges.

It is your responsibility to pay any deductible, co-insurance, or any other balance not paid by your insurance carrier.

Please remember your insurance policy is between you and your insurance company and not with the insurance company and your doctor.

The intention of this notice is to clarify our policies and procedures and promote good communication between our patients and our office.

I understand the billing procedures associated with this office and completely understand additional charges will be incurred if I fail to comply. I also, acknowledge that if I do not pay in full for services rendered, on the date of service, I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, Private Insurance and any other health plan to Michigan Sports Medicine and Orthopedic Center, P.C.. A photocopy of this policy is to be considered as valid as the original. I further authorize Michigan Sports Medicine and Orthopedic Center, P.C. be allowed to release information regarding my treatment in order to receive payment.

Print Patient Name

Signature of Patient and/or Guardian if under 18

Date

Relationship to Patient

Patients under 18 must be accompanied by a parent or guardian