# Rockowitz Orthopaedic Center/R.O.C.

**Is there:** ATTORNEY and/or AUTOMOBILE INSURANCE REPRESENTATION FOR THIS CONDITION? **Yes_____ No_____** If "Yes" please complete the portion below:

______________________________________________________________________

Attorney and/or Automobile Insurance Name Telephone Number

## Financial Agreement For:

**MEDICAL INSURANCE**: HMO, PPO, Medicare, etc. The PATIENT portion (co-pay, account balance) is due at TIME OF VISIT. It is the PATIENT'S responsibility to verify benefits with their insurance company prior to their visit.

**INDUSTRIAL INJURY**: Payment for the INITIAL and subsequent visits (while the claim is open) is pre-authorized and covered by the carrier. The PATIENT is responsible for payment if treatment is rendered after the claim becomes INVALID OR CLOSED.

**NO INSURANCE COVERAGE**: Full Payment is due at the time of service, unless PRIOR ARRANGEMENTS have been made. We will bill Out-of-Network Insurances as a courtesy.

**NO SHOW/LATE CANCELLATION**: A $25 fee will apply if a PATIENT misses an appointment with "NO" OR "LESS THAN" 24 HOUR NOTICE. The "No Show' fee must be paid before additional appointments will be scheduled.

### ROC Policy and Charges

Patient Account Balance is due at TIME OF VISIT for returning patients. If the entire balance is not paid within 30 days of the billing date, a FINANCE CHARGE will be added to the account for the current monthly billing period. This finance charge will be a periodic rate **of 1.8% per month, or a minimum monthly charge of $5.00**, which is an ANNUAL PERCENTAGE RATE OF 21% applied to the last month's balance. In the case of default of payment, the PATIENT or GUARDIAN promise to pay any interest on the balance due, as well as any collection costs and attorney's fees incurred to effect collection on the account.

### Method of Payment Options

Payments may be made by cash, check or credit/debit cards.

A **3%** card processing fee will be added to **credit/debit payments of over $500**.

## I understand and agree to the above policies:

X ________________________________________ Date________________

**Signature of Patient OR Guardian**

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