****

**Welcome To The Orthopedic Care Center**

To help ensure the highest quality of service and care to our patients we would like to inform you of our policies and procedures. If you have any questions or concerns, please address them with our staff prior to your office visit.

**We require that you bring the following to your visit:**

**Insurance Card(s)**

**Photo Identification or Valid Driver’s License**

**Co-Pay/Deductible for insurance patients and full payment for self-pay (cash, check or VISA/Mastercard)**

**Insurance Referral from your Primary Care Physician (if required by your insurance company)**

**Current Medication List to Include RX Name, dosage and frequency taken**

Please be aware that **The Orthopedic Care Center** has the right to cancel or reschedule your appointment if you fail to bring the required items.

**Patient Information:** A complete patient registration will be kept on file and will be updated by the patient every six months. It is the responsibility of the patient to inform our office of any demographic and/or insurance changes that occur prior to or after the required update period(s). A signature of the responsible party will also be required.

**Insurance Cards:** Patients are required to bring current insurance card(s) to each visit. If current insurance information is not provided, the patient will be expected to pay at the time services are rendered.

**Photo Identification:** A photo identification card or valid driver’s license is required at each visit. In order to protect the identity of our patients, we are now required by law to obtain this information. If proper identification is not presented at the time of visit, the Orthopedic Care Center reserves the right to cancel or reschedule the appointment.

**Co-Pays:** Co-pays are expected at the time of visit unless arrangements have been made with our office in advance. Co-pays may be paid by cash, check or VISA/Mastercard. We do **not** accept Discover Card or American Express.

**Deductibles:** Deductibles indicated by the patients insurance carrier will be collected prior to surgical procedures.

**NSF Checks:** A fee of $20.00 will be charged to the patient’s account for any returned checks due to non-sufficient funds.

**Authorizations/Referrals:** Authorizations and referrals are an agreement between the patient and their insurance carrier. If an insurance authorization/referral is not received prior to the patient’s appointment time, the Orthopedic Care Center reserves the right to cancel or reschedule an appointment. A cancelation fee may apply.

**Legal Guardians:** All minors are required to have a Parent or Guardian present with them at each visit unless arrangements in advance have been made with our office.

**Appointments:** Patients are required to be on time for their scheduled appointments. Patient’s arriving more than 15 minutes late may be asked to reschedule. Our office requires a 24 hour cancellation notice for patients who are unable to keep their scheduled appointment. If a 24 hour cancellation notice is not provided, a $20.00 non-refundable, pre-payment for future appointments may be requested.

**Self-Pay Patients:** Payment in full at the time of service is expected for patients with no insurance coverage. If payment in full at the time of service is not financially feasible, financial arrangements must be made **prior** to scheduling an office appointment or surgical procedure. If you need financial assistance, please call our billing department at **1-888-386-7757** to begin the application process.

**Past Due Accounts:** Payment is due upon receipt of a billing statement. Non-compliance may result in preparation of the account for collections, small claims court and/or credit bureau reporting and possible dismissal from our practice. In the event an account is sent for collection proceedings, the responsible party of the account will be responsible for all collection costs.

**Medical Records:** Upon written request, we will be happy to provide copies of a patient’s medical record. For medical record requests for dates of service on or after August 1, 2017, please contact our Release of Information Department at **317-736-3573** or email them at releaseinfo@johnsonmemorial.org. A fee will be charged for records requests received by entities other than personal physicians.

**Disability/FMLA Forms:** We are happy to complete any disability or FMLA forms for a fee of $15.00 per form. Fees must be paid prior to completion of the forms. The patient portion of the form(s) must be completed prior to us completing the physician portion.

**Prescriptions:** Prescription refills will **NOT** be authorized after hours. Prescription refills must be authorized by the physician and may take up to 24 to 48 working hours to obtain. Prescription refills will only be authorized during normal business hours which are Monday-Thursday 8:00am- 5:00pm and Friday 8:00am – 4:00pm.

**Use of Cell Phones and Other Electronic Devices:** We prohibit the use of cellular phones and other electronic devices in our office. If you need to make a call while you are in our office, we ask that you step out to the main lobby to do so as a courtesy to our other patients.

**Food and Beverages:** We do not allow food or beverages in our office. This policy is in effect because some of our patients have food allergies and or sensitivities. Please leave your food/beverages at home or in your vehicle. Any food or beverage brought into our office will be discarded of.

I have read and understand this policy. I agree and understand that such terms may be amended by our office at any time. I understand I have the right to request a copy of your office policy at any time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

(Patient Name- PLEASE PRINT) (Signature of patient or guardian) (Date)