WELCOME TO OUR OFFICE

WE FIND THAT COMMUNICATION WITH OUR PATIENTS REGARDING OUR BUSINESS OFFICE POLICIES ASSISTS US IN PROVIDING YOU THE BEST SERVICE. THEREFORE WE HAVE PROVIDED A HIGHLIGHT OF SOME IMPORTANT POINTS.

- Please advise us if you change your address, phone number, place of employment, or insurance.
- We do not accept responsibility for charges denied as a result of changes in your insurance coverage during the course of your treatment. Denials due to changes in your insurer and/or managed care organization are your financial responsibility.
- If we participate with your insurance plan, we will file an insurance claim for you. At the time of your visit, we expect payment for your percentage or portion that is not covered by insurance.
- Patients without insurance or patients with insurance plans in which we do not participate are expected to pay for charges at the time of service.
- It is your responsibility to obtain a referral from your primary care physician for services rendered in our office. Charges which are denied due to lack of a referral are your responsibility.
- Some insurers normally do not pay for supplies provided by our office. If we inform you that a supply prescribed by your physician will not be covered, we expect payment when you receive the supply. In the event that your insurance company is billed and does not remit payment, you will be billed for the supplies which are not paid.
- If you need to cancel or reschedule your appointment, you must do so at least 24 hours before you scheduled office appointment and 48 hours before your scheduled procedure. This notification is necessary so that we may schedule other patients needing immediate appointments.
- There is a $40.00 administrative fee for any forms (FMLA, Disability forms, etc) that are needed to be filled out.
- A fee of $35.00 will be added to your account for any check dishonored by your bank.

I have read the above business office policy statements. As a patient of Dominion Orthopaedic Clinic, LLC I understand my responsibilities.

PATIENT/GUARDIAN SIGNATURE*____

SIGNATURE*____

DATE OF SIGNATURE*____