Anne Arundel Orthopaedic Surgeons -- a division of Centers for Advanced Orthopaedics

Anne Arundel Orthopaedic Surgeons

Garrett J. Lynch, M.D. Louis J. Ruland, III, M.D., M.S.
Charles M. Ruland, M.D. Garth R. Smith, M.D.

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BOARD CERTIFIED FELLOWSHIP TRAINED ORTHOPAEDIC SURGEONS WITH SPECIALTY TRAINING IN:

Fracture Care • Sports Medicine • Hip, Knee, Shoulder and Ankle Replacement • Knee Surgery
Shoulder Surgery • Wrist and Elbow Surgery • Foot and Ankle Surgery
Spine Surgery • Pediatric Orthopaedics

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2003 Medical Parkway, Suite 400
Annapolis, MD 21401

4000 Mitchellville Rd., Suite A-214
Bowie, MD 20716

810 Landmark Drive, Suite 110
Glen Burnie, MD 21061

Phone (410) 573-2530 Fax (410) 573-2536 www.aaos.net

FINANCIAL POLICY FOR ANNE ARUNDEL ORTHOPAEDIC SURGEONS (AAOS)

- **Payment for services rendered** by AAOS is due and payable in full at the time services are rendered, unless prior arrangements have bee made with an employee of AAOS.

- **Any balance unpaid after 60 days** from the date services were rendered will be subject to interest at the annual percentage rate of 18% with a $2.00 minimum.

- **Re-billing Fee:** A re-billing fee of $2 will be imposed on each account that is over thirty days past due.

- **In the event** the Patient submits payment by check and that check is returned for any reason by the Bank, AAOS will add $25 to the balance owed by the Patient or Responsible Party.

- **For patients with insurance:** Any cost sharing, such as co-payments, coinsurance and/or deductibles are the responsibility of the Patient and/or Responsible Party. In the event that services rendered are not covered, Patient and/or Responsible Party shall be responsible for payment in full for those services.

- **No statement by an employee** or agent of AAOS will contradict, void, or nullify this Agreement, nor shall the patient rely on any statements or opinions made by AAOS that Patient's insurance carrier will cover the bill.

- **Payments:** Unless other arrangements are approved by AAOS in writing, the balance on your statement is due and payable when the statement is issued, and is past due if payment is not received within 30 days.

- **Automatic Payment Plan:** The Automatic Payment Plan is a convenient way for you to make your monthly payment by using your credit card.

- **Insurance:** Insurance is a contract between you and your insurance company. AAOS is NOT a party to this contract, in most cases. AAOS will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company.

- **Required Payments:** Any co-payments required by an insurance company must be paid at the time of service.

- **Past Due Accounts:** If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency and/or a lawyer, you agree to pay all of the collection costs that are incurred, including lawyer's fees and court costs if applicable.

8.9.16

(SEE REVERSE SIDE FOR CONTINUATION OF OUR FINANCIAL POLICY)

Kimberly A. Stauffer, M.S., C.R.N.P. Christy L. Crowther, M.S., C.R.N.P
Shawn S. Simpson, M.M.S., P.A.-C.

CONTINUATION OF FINANCIAL POLICY FOR ANNE ARUNDEL ORTHOPAEDIC SURGEONS

▲ **Waiver of Confidentiality:** You understand if your account is submitted to an attorney and/or collection agency, if AAOS has to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at AAOS will become a matter of public record.

▲ **Co-Signature:** If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

▲ **Effective Date:** Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize AAOS to release all medical and billing information necessary to secure payment from any insurance carrier on my behalf.

Authorization is hereby given to AAOS to submit my claim directly to my insurance company on my behalf. I understand that by signing this form, my signature is not needed each time a claim is submitted on my behalf. I further authorize my insurance carrier to forward payment directly to AAOS.

CONFIDENTIAL COMMUNICATION OF PERSONAL HEALTH INFORMATION

(Please provide us with the below information)

WHEN CONTACTING YOU:

Patient Name: _____ Date of Birth: _____

Telephone #: _____ Is this a home or work #: ( ) Home ( ) Work

May we contact you on your cell phone? ( ) Yes ( ) No If yes, cell #: _____

Best time of day to reach you: _____

If when calling, we reach an answering machine or voice mail message, may we leave a message? ( ) **Y** ( ) **N**

May we leave messages with another party? ( ) **Y** ( ) **N** If yes, with whom?: _____

AUTHORIZATION AND ACKNOWLEDGEMENT

By my signature affixed below, I acknowledge that I have read and agree to comply with the Financial Policy for Anne Arundel Orthopaedic Surgeons as previously described, that I give my authorization as described in the section titled Authorization for Release of Medical Records, that I have provided the information as requested above in the section titled Confidential Communication of Personal Health Information and that I have received a copy of the Anne Arundel Orthopaedic Surgeons Notice of Privacy Practices

_____ _____

Signature of Patient or Parent/Guardian, if minor Date

_____ _____

If Responsible Party, Please Print Name Relationship to Patient

_____ _____

Witness *Account # (For Office Use)*

7.25.16

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