

## **FINANCIAL POLICY**

**Thank you for your confidence in choosing OrthoSports, LLC for your orthopaedic needs. Our staff is committed to ensuring that your medical care and treatment is a mutually satisfying experience. Since payment of your bill is part of your treatment, we want to be sure that our financial policies are clearly understood before we begin treatment. Please read, sign and date the following financial policy and ask any questions that you may have prior to your appointment.**

**Full payment is required at the time services are rendered. For your convenience we accept cash, check and all major credit cards.**

**Our practitioners are providers for many managed care insurance companies; however you are ultimately responsible for any co-payments, coinsurance and/or deductibles at the time services are performed. We will gladly file your insurance claim to your insurance carrier for all companies with whom we are contracted with. If we are not contracted with your insurance company, you will be required to pay for services as they are rendered. We will provide you with all the information necessary to file your claim and receive reimbursement directly from your insurance company.**

**Payment of your account is your responsibility regardless of your insurance coverage. Your insurance is a contract between yourself and the insurance carrier. We are not a party to that contract. If your insurance does not pay your claim within 45 days, any balance due will become your responsibility.**

**Please be aware that your insurance company will pay only for services they regard as “reasonable and necessary” according to the guidelines of your particular policy. You will be responsible for payment of any non-covered service in full including any non-covered durable medical equipment (i.e. braces, crutches, walkers, cast shoes, arm slings, ace wraps, cold therapy machines, casting material, etc)**

**Patients who are scheduled for surgery will be required to pay any co-payments, coinsurance and/or deductibles prior to the surgery. If we are not contracted with your insurance company or you do not have coverage, a 50% deposit of the estimated cost of your surgery will be required. The balance will be due within 30 days following surgery.**

**I agree to pay any balance not paid by my insurance carrier. I agree to any necessary fee involved with collection of this account should it become delinquent. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits to be made to the party who accepts assignment.**

**I have read and agree to abide by the financial policy set forth by the office of OrthoSports, LLC**

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**Patient or Designated Representative Signature**

**Printed Name**

**Date**