**FINANCIAL POLICY**

*We are committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order for us to accomplish this in a cost-effective manner, we ask that you adhere to the following guidelines.*

- I agree to furnish ***Sports Medicine & Orthopaedic Centers*** with a copy of my current health insurance card(s). I also agree to provide an explanation of benefits and/or claim form(s) from my insurance company, when applicable.
- I authorize the release of medical information necessary to process my insurance claim and I assign insurance benefits to ***Sports Medicine & Orthopaedic Centers*** for services provided to me by Sports Medicine & Orthopaedic Centers health care providers.
- I understand that co-pays are due at the time of service, as required by my insurance company, before being seen by a ***Sports Medicine & Orthopaedic Centers*** heath care provider.
- I understand that if the amount of my co-pay for an office visit is unknown, or ***Sports Medicine & Orthopaedic Centers*** cannot determine my co-pay, ***Sports Medicine & Orthopaedic Centers*** will charge me a flat $40 co-pay for each visit. If this amount is an overpayment after the correct patient copay is determined, I understand that my account will be credited toward future office visits. I may also ask for my credit card to be refunded. The standard cost of the office visit will be submitted on my behalf to my insurance company for reimbursement of the insurance portion of the office visit.
- I agree that I will be responsible for balances applied to my account that are not covered by my health insurance plan.
- I understand that my account will be charged $75 when a check I presented for payment is returned and marked “non-sufficient funds” (NSF). Returned checks over $500 will be assessed a fee of 10% of the amount of the check.
- I understand that ***Sports Medicine & Orthopaedic Centers*** will bill my health insurance company and will refund any overpayment on my account to the appropriate party (i.e., insurance company, patient).
- I understand that ***Sports Medicine & Orthopaedic Centers*** allows 30 days for the processing of my claim by the insurance company. In the event the practice does not receive reimbursement within 45 days, Sports Medicine & Orthopaedic Centers will contact my insurance company regarding the claim; I will be notified if they do not receive a response.

- In the event I am unable to pay my responsibility in full, I will contact the office to discuss financial arrangements.
- If you plan to pay privately for your services, please be advised that it is the policy of ***Sports Medicine & Orthopaedic Centers*** practice to collect payment in full at the time of service. If you are unable to make payment in full at the time of service, your appointment will be rescheduled to a more convenient time.
- I accept full financial responsibility for all charges, insurance balances, self-pay balances and other fees that may not be covered by my medical plan.
- I consent to the release of my protected healthcare information to credit card companies, banks and financing companies in the event a charge is disputed.

I acknowledge that I have received a copy of this financial policy. I agree to read this document and comply with the terms set forth for services rendered by ***Sports Medicine & Orthopaedic Centers.***

_____

Patient Signature (Guarantor) Date

_____

Witness Date