

IRVING ORTHOPEDICS & SPORTS MEDICINE

Thank you for choosing Irving Orthopedics & Sports Medicine as your health care provider. We are committed to the success of your treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

Full payment is due at the time of service

We accept cash, checks or Visa / MasterCard / American Express

We offer an extended payment plan with prior approval

INSURANCE

We may accept assignment of insurance benefits upon your first visit. However, we do require your portion of the bill to be paid at the time of service (i.e.. co pay, deductible etc.) . Because the bill is your responsibility, should your insurance company not pay - you will be billed the remaining balance. We will do everything reasonably required to facilitate the filling of your insurance claim. This necessitates you providing us with your insurance information along with all other relevant documents (i.e.. accident reports, secondary insurance, workman's compensation etc.). Your insurance policy is a contract between you and your insurance company. Please be aware that your insurance carrier may deny coverage that is usual, customary and in our opinion medically necessary - declaring the treatment not necessary or not covered. Should this occur you will be responsible for the entire bill and any and all reasonable costs. If your account becomes 90 days delinquent you understand your account will be submitted to a collection agency.

Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MINOR PATIENTS

The adult accompanying a minor and the parent (or guardians) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, VISA / MasterCard, or payment by cash or check at the time of service. Minor patients must also have a signed consent to treat by their parent or guardian.

MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit (subject to extenuating circumstances). Please help us serve you better by keeping scheduled appointments.

RETURNED CHECKS

There will be a \$25.00 service charge on returned checks.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I understand and agree to this Financial Policy.

Signature of patient

Date _____

Signature of responsible party

Date _____