

COMMUNITY ORTHOPEDIC SURGERY, P.C. & HURON VALLEY HAND SURGERY

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a *statement of our Financial Policy* that we require you read and sign prior to any treatment. ALL PATIENTS MUST complete our INFORMATION AND INSURANCE FORM before seeing the doctor.

PAYMENT IS DUE AT THE TIME OF SERVICE

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER OR AMERICAN EXPRESS

REGARDING INSURANCE PLANS WE DO NOT PARTICIPATE WITH:

We require that charges be paid in full at the time of service when the charges are \$200.00 or less. We will provide you with an itemized receipt that you can turn in to your insurance company for reimbursement. For charges exceeding \$200.00, we will submit the charges to your insurance carrier on your behalf; however, you are responsible for the balance not paid by your insurance carrier.

Since we are not a party to the agreement with your insurance carrier, it is NOT OUR POLICY to contact carriers to establish why they have not paid or why they paid less than originally indicated. *Please be aware that some, and perhaps all, of the services provided may be non-covered and not considered reasonable and necessary under your insurance carrier.*

Patients having an elective surgical procedure will be required to pay a **down-payment of 20% of the physician's surgery fee** before surgery will be scheduled.

USUAL AND CUSTOMARY RATES:

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

Adult Patients: Adult patients are responsible for full payment at the time of service.

Minor Patients: The adults accompanying a minor and both parents (or guardians of the minor) are responsible for full payment. For **unaccompanied minors, non-emergency treatment may be denied if parental consent to treat the minor does not accompany the patient** along with pre-authorization for charges to an approved credit card, Visa, Mastercard, Discover or American Express, or payment by cash or check at the time of service has been verified.

REGARDING INSURANCE PLANS WE DO PARTICIPATE WITH:

We require that co-pays and charges for non-covered services be paid at the time of service.

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

I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of Patient or Responsible Party

Date