

Center for Orthopaedics and Sports Medicine

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PLEASE READ THIS FINANCIAL POLICY CAREFULLY

- You are ultimately responsible for all charges incurred. We accept cash, check and the following credit cards: Mastercard, Visa and Discover.
- As a courtesy we will file your charges with your primary insurance company. We will also file once with your secondary insurance. All services provided by our physicians are medically necessary. However, your insurance company determines which of those services it will pay according to your policy.
- We collect all co-pays, outstanding deductibles, and non-covered services at the time services are rendered. We also collect if your insurance does not pay us directly in a timely manner. Balances of \$50 or greater will be collected at check in.
- We will collect in full at the time of service if your visit is payable by a third party insurance such as: automobile insurance, homeowners insurance, slip and fall cases or any case involved with litigation.
- If you are having surgery, you will be required to pay all co-pays and deductibles prior to surgery.
- Injuries involving fractures and/or surgery are billed on a flat-fee (global) basis. This flat-fee includes the professional follow-up care for the specific problem, normally for a period of 90 days. This fee does not include casts, medical goods or equipment, x-rays or tests.
- We appreciate your cooperation in working with us in the processing of your charges with your insurance company. Your account will remain open and pending until all charges are fully paid by you and/or your insurance company.
- If you were seen in the E.R. or had emergency surgery we expect payment arrangements will be made at your first follow up visit.
- If a statement has to be mailed out more than once, there will be a first class postage charge on all future statements. We will also add any collection or court charges to your account.
- All fees associated with returned payments will be assessed to the patient.
- A \$25 fee may be charged for appointments cancelled with less than 24 hour notice.

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and open communication. We are available to clarify any misunderstandings you might have concerning your account.

I have read, understand and agree with this financial policy.

Patient signature _____ Date _____