

**FAIR OAKS ORTHOPAEDIC ASSOCIATES
FINANCIAL POLICY**

Fair Oaks Orthopaedic Associates is dedicated to providing our patients with the best possible care. We ask your help by understanding and cooperating with our financial policy.

Insurances:

We participate with many insurance companies. Please check with your insurance company to confirm that we participate with your plan. We will file secondary and tertiary insurances as a courtesy to our patients.

If we do participate with your insurance company, all services performed in our office and at the hospital will be submitted unless we have received prior notification of non-coverage. All copays and deductibles are the patient's responsibility and are due at the time of service.

HMO insurances generally require referrals for services. It is the patient's responsibility to obtain the referral. If a referral is not presented at the time of service, the practice reserves the right to reschedule the appointment.

If we do not participate with your insurance and you have no "out of network" benefits, payment is due in full at the time of service. We will provide you with an itemized bill so that you can submit the charges to your insurance company for reimbursement.

It is the patient's/parent's/guardian's responsibility to:

***Understand that your health insurance coverage is an agreement between you and your insurance company. Ultimately, it is your responsibility to know the terms of your healthcare plan.**

***Be aware that Durable Medical Equipment (DME) may not be covered under your plan.**

***Bring all of your current insurance cards to all visits.**

***Provide our practice with current information including address, phone numbers and employer.**

Payment for Services Performed:

For your convenience, our office accepts Visa, MasterCard and Discover as well as cash or checks. All payments are due at the time of service. The fee for the completion of FMLA and Disability Forms is \$25.00 and is due at the time of the request.

Should your account become delinquent and be turned over to a collection agency, you will be financially responsible for all collection and legal fees that our office incurs.

The fee for a returned check is \$50.00.

I have read and fully understand the financial policy set forth by Fair Oaks Orthopaedic Associates and I agree to these terms. I also understand and agree that the terms of this policy may be amended by the practice at any time without prior notification to the patient.

Patient's/Guardian Signature

Date

Printed name of patient

Date