FINANCIAL PAYMENT POLICY
of
North State Orthopaedics

Thank you for taking the time to read this policy statement. We find that communication with our patients regarding our financial policy assists us in providing the best service to you. We believe this helps prevent misunderstandings about your bill. We prefer to maintain your account in our office instead of sending it to an outside agency. Here are the answers to some of the most commonly asked questions. If you have more to ask, please let us know.

1. **REGARDING INSURANCE: As a courtesy to our patients, we will bill your insurance company for any office visits and treatments performed. Because the doctor's service is provided directly to you and not to the insurance company, we ask you to take ultimate responsibility for payment of the doctor's bill. If the insurance company has not paid the doctor within 60 days, we will count on you to pay the balance of your bill in full. You will still have the opportunity to be repaid by your insurance company.**

2. **CO-PAYMENTS: Any co-payments required by your insurance carrier must be paid at the time of service. We accept cash, personal checks, Visa, and MasterCard.**

3. **CHECK ACCEPTANCE POLICY: Our medical office has established the following policy for accepting checks and collecting bad checks: For a check to be an acceptable form of payment it must include your current and accurate name, address, telephone number, driver's license number, and state. In the event that your check is returned for non-payment, the face value may be recovered electronically along with a state allowed recovery fee. In the event that your check is returned for non-payment, checks will no longer be an acceptable form of payment for your account.**

4. **SPECIAL NEEDS: We understand you may have a special financial need. It may be necessary to set up a payment plan for a patient requiring extensive treatment. If this situation is necessary for you or your family, please bring this to our attention as soon as possible.**

5. **PATIENTS WITHOUT INSURANCE: Occasionally our patients may find themselves without health insurance coverage. Our policy is that 50% of all anticipated charges must be paid at the time service is rendered. A payment plan through a third party lender can be developed to meet your individual needs.**

6. **MEDI-CAL: If you are eligible or think you may be eligible to receive Medi-Cal assistance, we will help you with application information. If you are not registered with Medi-Cal, we will collect the estimated amount of payment from Medi-Cal. You will receive a refund of that amount when we are paid by Medi-Cal for your care.**

7. **FORMS: Any forms filled out by this office are subject to a fee of $15.00 for the first form completed and $5.00 for any additional forms. This fee renews annually and is not billed to your insurance. Some examples of forms that are subject to this fee are: disability claim forms, DMV forms, jury service, AFLAC, credit card, and FMLA.**

WE ARE HERE TO HELP!

I acknowledge full financial responsibility for services deemed medically necessary and rendered by Doctors Mikulecky, Paul, Osborne, Pemberton, or their assistants. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including coinsurance, deductibles, and co-pays. I understand payment of co-pays is expected at time of service as well as any prior balance I may owe. I also consent that the payment of authorized medical insurance benefits be made on my behalf directly to Doctors Mikulecky, Paul, Osborne, and Pemberton for any medical or surgical services furnished. I agree to all reasonable attorney fees and collection costs in the event of default of payment of my charges, as outlined in office and financial policies guidelines.

Signed _____ **Date** _____