



Our Financial Policy

Welcome to Associated Orthopedics, S.C. We are committed to the success of your medical treatment and care. Following is a statement of our Financial Policy, which we require patients to read, agree to and sign prior to non-emergency treatment.

- All patients must complete our “Patient Information Form” before seeing the doctor.
- Co-payments are to be made at the time of service.
- We accept cash, check, VISA and MasterCard.

Insurance Reimbursement, Customary Payments and Protection Letters

Although it is your responsibility to understand your medical insurance benefits, we will help you receive the benefits you are entitled to. Our office will provide you with a receipt to forward to your insurance company for your reimbursement of eligible charges. This receipt contains all of the diagnoses and procedure codes required by insurance companies.

Our office does not accept, except per existing contracts, insurance company “usual and customary” payments. Nor do we accept “letters of protection”.

Ultimate Responsibility

Upon receipt of payment from your primary insurance carrier, the entire remaining balance becomes due by you. If your insurance carrier does not respond to the claim within sixty days, then the entire amount is due and payable at that time by the undersigned.

If you do not have medical insurance, we will share your payment options with you. If your medical treatment is the result of workman’s compensation or personal liability, the ultimate responsibility for medical bills remains with you. The only exception is for claims that have been approved by workman’s compensation. For more details, please see document titled Workman’s Compensation Claims.

Patient Agreement

I, the undersigned, understand that I am financially responsible for the total cost of any services rendered to me. I am also advised that unless payment is received in a timely manner, prompt legal action may be instituted. This may result in judgment, garnishment or other legal remedies. I will be responsible for any and all costs associated with the collection of the account including attorney fees, filing fees, court costs and contractual interest that may be incurred.

I acknowledge reading and understanding all of the statements and policies listed above. I hereby authorize the release of any information necessary to file a claim with my insurance company. I hereby assign benefits otherwise payable to Associated Orthopedics, S.C.

Signature: _____ Date: _____

Relationship to patient: _____

Insurance billing services information given to patient. _____ (initials)