Financial Policy

Steingart Orthopedics is dedicated to defining the standard of patient care through a commitment to excellence and quality care for our patients. **Steingart Orthopedics** has a responsibility to operate in a financially prudent manner to allow us to continue our mission; this includes collecting amounts due prior to rendering services. Amounts due include personal obligations such as co-pays, deductibles and past due balances.

Steingart Orthopedics values demand that our patients come first, we must be financially responsible to continue to serve. For those patients experiencing financial hardships we offer financial assistance options when necessary and appropriate. This includes helping setting up payment plans when needed.

I understand that it is my responsibility to know my insurance benefits and plan coverage. My insurance may or may not cover the services provided at **Steingart Orthopedics**. To obtain the most accurate information, please check with your insurance carrier to discuss the benefits provided by your medical plan prior to your visit to fully understand your anticipated out of pocket costs.

I understand that payment of co-payments, deductibles and non-covered services are to be paid at or before the time of service**. Steingart Orthopedics** accepts cash, checks, MasterCard, Visa, Discover, American Express and Debit Cards. You may also pay your bill over the phone or in person with a billing representative.

I understand that if I do not have my insurance information, referral, and/or co-payment, that my appointment may be rescheduled until such time that I can provide the required documents or payments.

I understand that **Steingart Orthopedics** will collect, prior to any surgery or procedure, deductibles and coinsurance up to an amount equal to payment in full for the planned surgical procedure. Payment in full and expected coinsurance payment responsibility are determined by the anticipated surgical billing code(s), details of your insurance policy, and agreement between your insurance company and **Steingart Orthopedics.** If the full deductible is not applied to your claim by your insurance company, **Steingart Orthopedics** will refund any overpayment to you when we receive overpayment.

I understand if my account has an outstanding balance that is not paid in full within 90 days then my account will be placed on a collection status. No additional appointments will be made for delinquent accounts until the balance is paid or a payment plan is put into effect. If no action is taken **Steingart Orthopedics** may turn your account to an outside collection agency.

I understand that a $30 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check.

I understand that I have 24 hours before my appointment to cancel or reschedule. If I do not show-up for my appointment and did not cancel in time, a $35 no-show fee will be charged to my account. I understand after three no show appointments I will be discharged from **Steingart Orthopedics'** care.

I understand that there may be fees associated with medical records requests and completion of forms by a physician. I understand that I may be responsible for these fees. And the request may take up to 7-10 business days to be completed.

Statement of Financial Responsibility: I acknowledge I am responsible for all charges for services provided, including any amount not paid by my health care plan(s). This also applies if I am covered by Medicare, a health maintenance organization (HMO), or any other payer. I agree that **Steingart Orthopedics** may require financial information to determine eligibility for financial assistance and/or payment plan options. Information on financial assistance is available by contacting our office at **602-923-8500** and asking to speak with our Billing Department.

I have read and I understand the above Financial Policy and I agree to abide by its terms.

Print Name: _____ **Signature**: _____ **Date**:_____