

**Monterey Joint Replacement and Sports Medicine**

**FINANCIAL POLICY**

**Payments:**

Full payment and/or co-payments are due at the time services are rendered. We accept cash, checks and credit cards.

**Payment for Procedures or Surgery**

If you are scheduled to have a procedure, we can provide you with a best estimate of charges, however, until the procedure is performed it is not possible to quote the exact amount. Our office will call your insurance company to obtain authorization, if required, and obtain an estimate of the portion that is your responsibility. ***Pre-authorization is not a guarantee of payment.*** Any estimated out of pocket expenses are due prior to your procedure.

**Insurance:**

As a courtesy to our patients, we will bill your primary and secondary insurance carriers. We do not guarantee that your insurance will cover our services. It is your responsibility to keep our office updated with your most current insurance information and to verify that you have coverage for services provided by our office. We are contracted providers for most insurance carriers. We recommend that you verify this information prior to being seen in our office.

An itemized statement will be sent to you after your insurance company has processed your claim for services. If your insurance company has not processed your claim within 45 days, we reserve the right to bill you for the full balance.

**My options if I don't have insurance:**

Full payment is due at the time of services. If you do not have insurance and cannot pay your balance in full our office manager will discuss payment options will you.

**Return Checks Policy/ Non-payment of services:**

Checks returned to our office for insufficient funds are subject to a \$25.00 service charge. Every effort will be made to work with our patients on a reasonable payment plan; however, we reserve the right to send an account with a balance over 90 days old to an outside collection agency. If it becomes necessary to send an account to collection, the patient may be discharged from the practice.

I have read and understand the terms of this financial policy. I agree to comply with the terms set forth in this policy for services rendered by Monterey Joint Replacement and Sports Medicine.

Patient Name \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_