

# ALLSTAR ORTHOPEDICS

## PATIENT OFFICE FINANCIAL POLICY

Our office wants all of our patients to be able to comfortably afford orthopedic care. We proudly offer the following financial policy so that you can have the opportunity to decide which payment option best suits your needs. Please initial each paragraph and sign and date this agreement.

\_\_\_\_\_ You will be expected to pay any deductibles, co-payments, and fees for services at the time of any office related service.

\_\_\_\_\_ Our office will gladly work with your insurance company to help you get the maximum benefit available. We will estimate as closely as possible your insurance coverage and patient balance. Your options for payments are Cash, Check Visa, MasterCard, Discover.

\_\_\_\_\_ 24 Hour notice for appointment cancellations or a \$30.00 cancellation fee will be billed to your account.

I will be paying for my patient balance with the following

\_\_\_\_\_ Cash

\_\_\_\_\_ Check

\_\_\_\_\_ Credit Card

\_\_\_\_\_ Visa      \_\_\_\_\_ MasterCard      \_\_\_\_\_ Discover

\_\_\_\_\_ In the event of an unpaid patient balance,

    \*\*We reserve the right to charge interest to your account at a rate up to the state maximum.

    \*\*We reserve the right to refer your account to an outside collection agency after a period of 90 days.

\_\_\_\_\_ If your account is referred to a collection agency for an outstanding balance, you will be responsible for paying any, interest fees, collections costs, attorney fees, and court costs that we may incur to settle your account up to the maximum of 33.3% of your account balance.

\_\_\_\_\_ There is a \$30 fee for a returned check.

I have read and understand the terms of this agreement.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient or responsible party if patient is minor