DESIO

SPORTS MEDICINE

Financial Policy

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. I authorize the physician to release any medical information necessary to process all insurance claims.

2. If your insurance company requires a referral to see a specialist and we have not received one, you will be responsible for all charges incurred.

3. Keep in mind that your insurance policy is a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor—in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

4. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and if your insurance company requires a copayment, it due at the time of your visit.

5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

6. Re: Motor Vehicle/Personal Injury Claims- This office does not take care of patients that have been in motor vehicle accidents or slip and fall (personal injury claims) without expressed prior approval by the physician. This is something that needs to be arranged in advance. If it comes up that this is a slip and fall or motor vehicle accident etc. when it was originally booked as a regular referral, then the appointment will be cancelled and all copayments will be refunded if collected.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____
Signature of patient (or responsible party, if minor)   **Date**

_____
Print name of patient