TOTAL ORTHOPEDIC CARE

ORTHOPEDIC SURGEON

Paul M. Dimond, M.D.

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Total Orthopedic Care's Financial Policy

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

1. Payment is due at the time of service unless arrangements have been made in advance. (Please see our attached "Patient Payment Policy") We accept Cash, Check, Visa and MasterCard. Please be advised there is a $15.00 returned check charge.

2. Keep in mind that your insurance policy is basically 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.

3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a co-payment at the time of your visit.

4. If you are insured by a plan that we do not have a prior agreement with, our charges for your care are due at the time of service.

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

6. We will bill your insurance company for all services provided by our physician in the hospital. You are responsible for any balance due.

7. If your medical insurance coverage changes any time during your treatment, you must notify us at your earliest convenience and provide us with a copy your new insurance card.

I have read, understand, and agree to the above and attached Financial & Office Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

I also understand and agree that such terms may be amended by Total Orthopedic Care from time to time.

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

Please print the name of the above signature

Please print the name of the patient