

SIERRA PACIFIC ORTHOPAEDIC CENTER
MEDICAL GROUP, INC.

Financial Policy

Welcome to Sierra Pacific Orthopaedic Center Medical Group, Inc. We would like to take this time to acquaint you with the financial policies of our group. Our goal is to provide you with the highest quality care possible. In order to maintain our goal, we have highly trained staff available to help answer questions you may have regarding your treatment, insurance or billing issues. Please do not hesitate to ask for assistance.

Our office contracts with certain Preferred Provider Organizations (PPOs). If your health care expenses are covered by one of these plans, we require that you pay all deductible, co-pay and co-insurance amount at the time of service. We will bill your plan for remaining balance. If we do not contract with your plan, we require payment in full at the time of service. Please remember medical services are rendered directly to each patient at their request, therefore, each patient is responsible to us for payment.

A copy of your insurance card is required at each visit. It is your responsibility to notify Sierra Pacific Orthopaedic Center Medical Group, Inc of any changes. This information will be kept in your medical file.

You will receive a monthly statement whenever there is a balance due. Charges billed to your insurance plan will be noted on your statement until payment and/or an explanation of benefits (EOB) is received from the insurance company. We will bill your plan directly as a service to you, but not in substitute of your primary responsibility for payment. Charges which have not been paid by the insurance are the patient's responsibility. All patient due balances are expected to be paid within thirty (30) days of receipt of a statement. There will be a \$20 service charge on all returned checks.

Requests for alternate methods of payment will be reviewed on an individual basis. Every effort will be made to come to an agreed upon method of payment.

Some of the physicians in the Sierra Pacific Orthopaedic Center Medical Group, Inc., have a financial interest in the following facilities:

Fresno Surgery Center
Summit Surgical

I have read the above policy and agree to comply with the provisions. I understand that I am responsible for payment for all medical services rendered. I understand that if I am covered by a third party payment service such as an insurance plan, your office may bill them directly as a convenience to me, but that I am personally responsible for such charges until they are paid in full. **Assignment and Release:** I hereby authorize my insurance benefits to be paid directly to *SIERRA PACIFIC ORTHOPAEDIC AND SPINE CENTER MEDICAL GROUP, INC.*, and that I am financially responsible for services that the insurance considers to be non-covered. I authorize *SIERRA PACIFIC ORTHOPAEDIC AND SPINE CENTER MEDICAL GROUP, INC.*, to release any information required to process my claim.

Responsible Party Signature: _____

Date: _____