ADVANCED MUSCULOSKELETAL CENTERS, PA

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Financial Policy

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions.

- All patients must complete and sign our "Patient Information Form" before seeing the doctor.

- PRIVATE HEALTH INSURANCE: An insurance form will be filed for you. Office visit co-payment portions will be expected at each visit to our office. Any deductible or additional co-payment will be billed to you after your insurance pays.

- HMO-PPO MANAGED CARE PLANS: You will be expected to pay any co-payment or deductible portion in accordance with your policy at each visit to our office. If we do not participate in your plan, you will follow the policy for private health insurance patients. IF A REFERRAL IS REQUIRED, YOU ARE RESPONSIBLE FOR BRINGING THE FORM OR AUTHORIZATION NUMBER WITH YOU; WITHOUT IT, YOU WILL NOT SEE THE DOCTOR.

- MEDICARE: A claim will be submitted for you. Both doctors participate.

- WORKER'S COMPENSATION: All office visits must be pre-authorized with your insurance carrier before your visit.

- NO FAULT/AUTO: Any deductible or co-payment will be billed to you after your insurance pays. If you have health insurance, we will balance bill for you.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD AND DISCOVER

MINORS MUST BE ACCOMPANIED BY AN ADULT: The adult accompanying a minor, and his/her parents (or guardians), are responsible for full payment.

UNACCOMPANIED MINORS: The parents (or guardians) must present written notification to the physician that identifies that they are responsible for full payment. Non-emergency treatment will be denied unless charges have been pre-authorized or paid by cash or check at the time of service.

ACCOUNTS 90 DAYS PAST DUE WILL BE SENT TO COLLECTION.
If the account is assigned to any attorney for collection and/or suit, reasonable attorney's fees and costs of collection will be added to the unpaid balance.

I HAVE FULLY REVIEWED THIS FINANCIAL POLICY STATEMENT AND AGREE TO HONOR THE TERMS OUTLINED. I FURTHER AUTHORIZE DISCLOSURE OF PORTIONS OF THE PATIENT RECORD WHICH ARE REQUESTED BY THE INSURANCE CARRIER. (These may be necessary to determine reimbursement.)

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Responsible Signature Date