SPECORTHO™
Specialty Orthopaedics & Sports Medicine, LLC

Financial Policy

Welcome to SpecOrtho, and thank you for choosing us as your orthopaedic healthcare provider. We are committed to providing you with exceptional convenient & personalized care. Our practice will work with you to help fullfill your payment responsibility. As the patient, you are responsible for any unpaid balance not contracturally covered by your insurance, including: copays, non-covered services, deductibles and co-insurance. Your participation in this process is essential to prevent any interruption in care.

By signing below, you confirm you have read this policy and understand the following:

- It is your responsibility to inform our office of any address, telephone number, or insurance changes.
- Copayments are collected at the time of service. Coinsurance and deductible amounts are also collected at time of service where possible.
- Self-pay patients, and patients with an insurance SpecOrtho does not participate with, will be provided a cost estimate which will be collected at time of service. **Pre-collection amounts are estimates only as we are unable to determine exact services performed prior to being seen.** You will be billed for any remaining amount due or refunded should you overpay.
- There is a $20 charge for completion of paperwork (disability, FMLA, etc).
- If you are unable to keep your appointment, please notify us in advance so we may offer that time slot to another patient.
- A pattern of repetitive “no show” or late cancellations may regretfully result in an assessment of a $50 cancellation / no show fee.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have questions about the above information, please do not hesitate to ask us. We are here to help you!

I hereby authorize and assign to SpecOrtho any and all benefit payments for services rendered under the terms of my insurance policies, and hereby individually obligate the payer to pay the account to SpecOrtho in accordance with the standard and customary charges incurred during my period of treatment. I understand I am responsible for all deductibles, co-pays, and charges for services rendered to me but not covered by my insurer. Should the account be referred for collection, I understand I shall pay the collection expenses incurred by SpecOrtho, without limitation to court costs and attorney’s fees.

I have read and understand the above Financial Policy and agree to meet all financial obligations.

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Patient signature (or parent, if under age 18) Date