Sierra Orthopedics, P.C.

Financial Policy

Our Doctors and Staff are very concerned about the cost of your healthcare and want to address some current issues related to the cost of medical services in this office. This is a statement of our financial policy. Considerable care has been taken in setting our fees. We want to assure you that the charges accurately reflect the complexity of care rendered and the skill and expertise required for your care. Our fees are comparable with fees of other Orthopedics in the area.

If an insurance company indicates a Physician's fees are above the "usual and customary", please understand that most Physician's fees are above the rate which insurance companies choose to pay. That rate is always lower than the current fees normally charged by any Physician. We use many sources to determine the appropriateness of our fees. We cannot and do not allow the payment or allowance of an insurance company to set the amount that we charge for services.

Our policy requires payment at the time of service. We provide you with a superbill to send your claim in.

HMO, PPO, Medicare, ICA's: If you are a member of an HMO, PPO, or Medicare, you must pay your deductible or co-pay at the time of service. You are also responsible to see that we have a current referral on hand if your insurance company requires one. If we do not have this referral at the time of the visit, your insurance company may hold you responsible for all charges. You may also be sent back to your Primary Care Physician prior to being treated, to obtain a current referral. Our agreement for payment is with you and not your insurance company. Payment to our office is not contingent nor dependent upon your insurance.

In your interest, we do accept Visa and MasterCard. Returned checks will receive a $15.00 overdraft charge. A collection agency may take over delinquent accounts at which time you will be responsible for all costs of collection. Timely payments will prevent such actions.

If you have any questions regarding any of the above, please feel free to contact our billing office.

I have read and understand my financial responsibilities under this policy.

Date:__________ Patient/ Responsible Party Signature: ____________________________