



Advanced Orthopedics and Sports Medicine, PLLC

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We are pleased that you have chosen this practice for your medical care.

We are committed to providing you with the best possible treatment. The following is a statement of our Financial Policy, which we ask that you read prior to any treatment. If you have any questions about our fees, our Financial Policy, or our mutual responsibilities, please ask our billing department to explain.

It is important that you complete our "Patient Information Form" before seeing the doctor, and that you notify us of any changes in your address or insurance coverage.

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED

- We accept cash, check and /or major credit card as forms of payment. A service charge will be made for all returned checks.
- If full payment at the time of service is not possible, special arrangements will be considered by this office at the time of service if an agreement is made with our billing department.
- Please note that most companies consider our fees usual, customary and reasonable.

INSURANCE

- If you are part of a managed care plan and we are participating providers, we will submit claims for you. Due to rapid changes taking place in the health insurance industry, it is imperative that you are aware of the benefits and requirements of your insurance plan. It is your responsibility to know and advise us of your plans in advance, each and every time we provide service. *Please be advised, that if we have not been informed of your programs requirements and if we provide a physician for services, you will be responsible for the fee.*
- If you have insurance, we will help you receive the maximum benefits to which you are entitled. We will help you complete claim forms so that you can be reimbursed by your insurance company to the full extent of your coverage. We will supply any additional information your insurance company deems necessary for proper processing of your claims. *However, the amount not covered by the insurance company remains your responsibility.*
- Even if we participate with your insurance company, part of the services provided may be your financial responsibility. This depends upon whether your annual deductible has been met as well as whether there is a co-payment required in your insurance policy. If you have secondary insurance, that policy may pay the remainder of the co-payment expense. However, the deductible is always the patient's responsibility.

Thank you for understanding our Financial Policy. We emphasize that your best medical care is our first concern. We wish to avoid confusion over financial matters which relate to your care. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X _____ Date ____/____/____
Signature of Patient or Responsible Party