TORRANCE MEMORIAL
PHYSICIAN NETWORK

FINANCIAL POLICY

We would like to thank you for choosing us to provide your orthopaedic care. We are committed to providing you with excellent and affordable healthcare. Because you may have questions regarding personal and insurance responsibility for services rendered, we have developed this payment and financial policy. Please read it, ask for clarification if needed, and sign in the space provided. A copy of this policy will be given to you.

All patients must complete the Patient Information and Insurance Form before seeing the doctor.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD AND DISCOVER.

Regarding Insurance Billing

You must provide proof of insurance. If you are not able to provide proof of insurance coverage, you will be considered uninsured and you will be responsible for fill payment at time of service. We will bill your insurance company as a courtesy. Your insurance policy is a contract between you and your insurance company. It is your responsibility to know your benefits and how they will apply to your treatment by the doctor. We are not a party to that contract. If your insurance company has not paid your account in full within 60 days, the balance will be transferred to you and/or the guarantor listed on the Patient Information form.

- **PPO Plans (with which we are contracted):** We have agreed to take a discount from your insurance company. Your co-insurance and/or unmet deductible is your responsibility and is due at time of treatment. In the event your insurance coverage changes to a plan where we are not a participating provider, you will be responsible for any out of network deductible or co-insurance amounts. All co-pays will be collected at the time of service. **If your co-payment is not made at time of service, a $20.00 administrative fee will be added to your account due and payable by you, not your insurance company.** If you are scheduled to have a surgical procedure you may be required to pay a $250 deposit for out-patient surgery or $500 deposit for in-patient surgery. This is a deposit which will secure your time on the doctor's surgery schedule. It will be applied toward any out-of-pocket expenses deemed patient responsibility by your insurance company. You *may* forfeit all or part of this deposit if you do not cancel your surgery in a timely fashion. Please ask the doctor's secretary for further details regarding this deposit.
- **Medicare:** We accept assignment with Medicare. Medicare pays 80% of their allowed amount after satisfaction of the annual deductible. We will bill your secondary insurance for the remaining 20% of the Medicare allowed amount as a courtesy; however, you are responsible for the balance regardless of payment from a secondary insurance. **We do not accept MediCal.**

Self-Pay Patients

Please be prepared to pay for service as they are rendered. We will be collecting a $250 fee upon check-in for new patients and $125 upon check-in for established patients. If surgery is needed, an estimate of your charges will be provided and a 50% payment deposit is required prior to the procedure. The deposit is for our services only. We cannot estimate the charges you may incur by other providers involved with your treatment. *Any overpayments will be credited to the account and refunded to the payer after the full course of treatment has been completed.*

Usual and Customary Rates/Out-of-Network

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Forms fee - There is a fee of $20.00 per form for completing disability and/or insurance forms. Payment for these is due when the form is dropped off. Please allow 5 business days to complete the form(s). For a full list of fees, please see receptionist.

Medical Imaging Request - There will be a fee for all requests on disk or film for MRI or X-Ray copies. Fees vary depending on request. Please see receptionist for a full list of these fees.

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

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Print Patient Name	Signature Patient/Parent/Guardian	Date