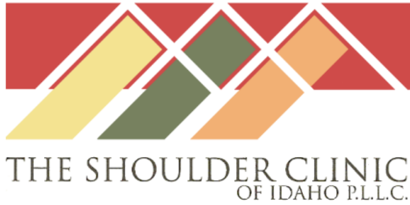

8854 W. Emerald St. Suite 102
Boise, ID 83704
Phone (208)323-4747 Fax (208)323-4848
Toll Free (866)786-9400

FINANCIAL POLICY

Thank you for choosing our practice for your shoulder health care. We are committed to giving you excellent medical treatment. The following is a statement of our financial policy that we require you to read and sign prior to any treatment. All patients must complete our "Patient Information Form" before seeing the provider. Full payment is due for your initial examination at the time of visit.

NO SHOW-CANCELLATION POLICY:

We ask that you make all of your scheduled appointments on time. We understand that emergencies do happen. Please cancel your appointment with at least 24 hours' notice so your appointment time can be offered to other patients. If less than a 24-hour cancellation is given, this will be documented as a "No-Show" appointment. If you do not arrive to your scheduled appointment, this will be documented as a "No-Show" appointment. After 3 "No Show" appointments, you may be dismissed from our clinic.

SELF-PAY: Payments on all accounts without insurance are due at the time of service unless you make other arrangements with our Practice Manager.

INSURANCE: Your insurance policy is a contract between you and your insurance company. We do bill all primary insurance for our patients. As a courtesy we will also bill secondary insurances one time.

We will extend credit for 45 days on approved insurance company benefits if such benefits are assigned to the clinic and if the clinic has sufficient information to verify coverage and submit a proper claim. After 45 days if your insurance company has not paid your account in full we require that you pay the balance.

SURGERY: If you require surgery, as part of the pre-operative process we will make an estimate of the professional fees associated with the surgery. This amount is only an estimate. Actual benefits paid may differ due to your insurance company's definition of UCR (Usual, Customary, and Reasonable). We require a deposit equal to the amount of your co-pay and deductible or 10% of the estimate of professional fees, whichever is less. This deposit is due before or upon the day of your surgery.

UNPAID ACCOUNTS AND INTEREST CHARGES: All unpaid accounts for which payment arrangements have not been made are subject to collection procedures. Any costs incurred in the collection of those accounts are added to the accounts. We charge interest on all unpaid balances that are over 90 days past due from the date we provided services to you, and refer these balances for collection. We reserve the right to charge interest at the rate of 1 ½% per month, 18% annually.

CREDIT OPTIONS AVAILABLE THROUGH THE CLINIC:

We accept the following forms of payment:

- Three equal payments within 90 days from the date of service without interest
- Cash
- Personal Checks
- Visa and MasterCard Credit Cards
- Debit Cards

I HAVE READ, UNDERSTAND, AND AGREE TO COMPLY WITH THIS FINANCIAL POLICY.

Date: ______________ Printed Name: ____

MM-DD-YYYY PRINT NAME OF PATIENT

Signature: ____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY