



**FINANCIAL POLICY**

Dear Patient:

Our office will be happy to bill your primary and secondary insurance carrier as a courtesy if the proper information has been provided.

If you do not have insurance, payment is due at the time of service. If you are a Medi-cal patient and do not have your eligibility card, you will be considered a "cash" patient and will be responsible for the balance due.

Several insurance companies have a "co-payment" that the patient is responsible for at the time of service. The office will bill the insurance company for the difference and you will not receive a statement. We will bill you for any services that are not covered. Please let the office know if you participate in this type of insurance plan or if you are required to have a referral authorization.

If you feel that your insurance company has not responded to your claim, or if you question the amount covered, please contact your insurance company. It is your responsibility to follow-up on claims submitted. We will be happy to assist you if necessary.

*To our HMO and EPO patients: Please read and sign the following liability statement.  
I, \_\_\_\_\_ will assume full financial liability for any non-covered benefit or service denied by my Health Plan. Example: Medical equipment, elective surgeries, etc.*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature*

**Release of Information/Assignment of Benefits**

I hereby authorize California Orthopaedic Institute to furnish to my insurance company or to a designated attorney, all information which the insurance company or attorney may request. I hereby assign to the above-referenced physicians all monies to which I am entitled and/or surgical expense relative to the services rendered by either of them. It is understood that any money received from the above-named insurance company, over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible, WHETHER MY INSURANCE COMPANY PAYS OR NOT, for all charges incurred by me. I further agree that in the event of non-payment, I will bear the cost of collection and/or Court cost and reasonable legal fees should such court action be required. I agree that a photocopy of this authorization shall be as valid as the original.

\_\_\_\_\_  
Insured or Guardian Signature

\_\_\_\_\_  
Patient's Signature

Date: