STEVEN SANDERS, M.D.

Thank you for choosing Steven Sanders, M.D. as your health care provider. We are committed to the success of your treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

Full payment is due at the time of service
We accept cash, checks, or Visa/ MasterCard/ American Express
We offer an extended payment plan with prior approval

INSURANCE

We may accept assignments of insurance benefits upon your first visit; however, we do require your portion of the bill to be paid at the time of service (i.e. co pay, deductible, etc.). Because the bill is your responsibility, should your insurance company not pay – you will receive a bill for the remaining balance. We will do everything reasonably required to facilitate the filling of your insurance claim. This necessitates you providing us with your insurance information, along with all other relevant documents (i.e. accident reports, secondary insurance, workman's compensation, etc.). Your insurance policy is a contract between you and your insurance company. Please be aware that your insurance may deny coverage that is usual, customary, and in our opinion medically necessary- declaring the treatment not necessary or not covered. Should this occur, you will be responsible for the entire bill. Should your account become 90 days delinquent, you understand your account will be submitted to a collection agency.

I hereby instruct and direct my Insurance Company to pay by check made out and mailed to: **Irving Orthopedics & Sports Medicine** or if my current policy prohibits direct payment to doctor, I hereby instruct and direct you to make out the check to me and mail it as follows: **2120 N. MacArthur Blvd., Suite 100, Irving, TX 75061**

Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not a participating provider, refer to the above paragraph.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize my doctor to initiate a complaint on my behalf to the Insurance Commissioner for any reason.

USUAL AND CUSTOMARY RATES

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 & customary rates.

PRIVATE PAY

There is a minimum deposit of $250.00 (for a general orthopedic physician visit or pain management physician visit) or $350.00 (for a spine orthopedic physician visit) due upfront for all private pay patients on the initial visit. All deposits must be cash or credit card only – no checks accepted. Due to the bill being your responsibility, should your charges add up to more than your deposit, you will be billed the remaining balance. Should your account become 90 days delinquent, you understand your account will be submitted to a collection agency. You will be responsible for all charges acquired during follow-up visits.

MINOR PATIENTS

The adult accompanying a minor and the parent (or guardians) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, VISA / MasterCard / AMEX, or payment by cash or check at the time of service. Minor patients must also have a signed consent form by their parent or guardian in order for our professionals to treat the minor.

MISSED APPOINTMENTS

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit (subject to extenuating circumstances). Please help us serve you better by keeping scheduled appointments.

RETURNED CHECKS

There will be a $30.00 service charge on returned checks.
Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.
By signing below, I am stating I understand and agree to this Financial Policy.

_____ _____

Signature of Patient or Responsible Party Date