

MICHIGAN STREET ORTHOPEDIC SPECIALISTS, P. C.

Bereza • Lovell • Ugolini

(616) 774-9515 Fax (616) 774-7116

FINANCIAL POLICY

Dear Patient,

We are committed to providing you with the best possible care. Our financial policy is a contract between you and the insurance company. We are not a part of that contract. Our fees are considered to fall within the acceptable range by most companies and therefore cover up to the maximum allowance determined by each carrier. This applies only to insurance companies who pay a percentage (such as 50% or 80%) of "UCR". "UCR" is defined as Usual, Customary and Reasonable by most companies. This statement does not apply to companies that reimburse based on arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of medical care in this area. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover, and some may require pre-certification and/or second opinion, before payment or denial.

- If we are non-participating with your insurance company, you will be responsible for payment.
- If you have an unauthorized office visit and/or surgery from your health insurance and/or workman's compensation, you will be responsible for payment.
- Please notify our office once you secure authorization.

We realize that temporary financial problems may affect timely payment on your account. If any problems arise, we encourage you to contact our office promptly for assistance in the management of your account. Please note that our charge for a returned check is \$15.00 plus the bank fee.

I hereby authorize the release of any healthcare information necessary to my employer, insurance company, physician, and to process claims for medical/surgical services. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance to either myself or Michigan Street Orthopedic Specialists, P.C. I have read all the information on both sides of this sheet and I certify this information is true and accurate to the best of my knowledge. I understand the provider's fees may exceed insurance payment and if greater than such payment, I will be responsible for that amount.

X _____ **Date** _____
Patient Signature (if a minor, parent or guardian signature)

X Please initial that you have reviewed this document.

2008 _____ 2009 _____ 2010 _____ 2011 _____ 2012 _____ 2013 _____ 2014 _____ 2015 _____