Financial/Credit Policy

Effective December 2007

Patient Name_____Account#_____

Zehr Center for Orthopaedics, PA, believes that in the interest of good health care practices, it is best to establish a patient account and financial policy between our patients and ourselves in order to avoid any misunderstandings. Our Practice Administrators will be glad to discuss your account with you at any time. Our primary responsibility is to deliver quality health care services. We wish to spend our time and energy toward that responsibility.

We expect you to show us the same consideration as you do your other creditors, and to be honest and forthright regarding your financial responsibility. We, therefore, ask you to read and accept the following statement of our financial policy prior to treatment. Payment is expected at the time of service, unless other arrangements have been made in advance. This includes applicable deductibles, co-insurance amounts and co-payments for participating insurance companies.

All patients must complete our information and insurance form before seeing the surgeon or his assistants. Please allow the office coordinator to copy your insurance card(s) and driver's license.

(PLEASE INITIAL THE FOLLOWING -- Indicating that you have read and agree with the statements)

_____1.) We expect that all co-pays, co-insurance and deductibles be paid in full at each visit and prior to surgery and diagnostic testing. We accept cash, check, Debit/Check Card, MasterCard, VISA, American Express and Discover. Any unpaid balance at time of service may be forwarded to an outside company for collection. You may qualify for financing through Care Credit, ask our Account Representative for details.

_____2.) We currently use an outside company to assist us in collecting balances due by our patients that are over 90 days old. It is important that you keep up with your statements and account balances and discuss any problems you may have satisfying your account with our Practice Administrator. You could be held responsible for expenses incurred in the collection of any past due balances.

_____3.) We file claims to your insurance company for your primary and secondary policies. Please remember insurance coverage is a contract between the patient and the insurance company.

_____4.) We do not file any insurance with your Automobile Insurance Company, or any other third party, (insurance company, employer, attorney, separated spouses, etc.) for purposes of obtaining payment. We will make every effort to provide you with proper documentation for you to receive reimbursement from those parties such as a claim form, a statement, or a report. We do not accept Letters of Guarantee or other promises to pay when cases settle. You will be extended credit only if arrangements are made in advance and only within our standard guidelines for credit.

Financial/Credit Policy (cont.)

_____5.) A service charge of $33.00 will be applied to returned checks. You will be asked to bring cash, money order or cashiers' check to our office to cover the amount of the check plus the service charge. If you present two (2) checks that are returned to us, we will require cash for future services.

_____6.) Invoices with balances are due and payable no later than 30 days from the invoiced date. Failure to pay the entire account balance within the aforementioned time will result in added interest charges of 1.5% per month (compounded monthly). An additional 10% late fee penalty shall also be due on invoices with balances not paid within 30 days. Patient "no shows" and cancellations within 24 hours are assessed a $50 fee.

_____7.) I agree that all payments that are sent to ZEHR CENTER for ORTHOPAEDICS, P.A., whether paid directly or via a third party shall be made without conditions or restrictions. In addition, I agree **NOT** to send checks to ZEHR CENTER for ORTHOPAEDICS, P.A. with any restrictive endorsements of any kind (i.e. , language indicating "paid in full") and understand that if I do send a restricted check (or a third party does this for me), this language is not a binding agreement. The endorsement and acceptance of this policy by ZEHR CENTER for ORTHOPAEDICS, P.A. shall not be deemed a waiver of any right or claim that it may have in regard to my remaining, current and future account balance(s).

If you have any questions about our financial policy, please feel free to discuss it with our Practice Administrator.

I have carefully read and fully understand my financial responsibilities under this policy. I agree that ultimately, my account is my responsibility.

Patient/Guardian
Signature_____Date_____