Garey Orthopedic Medical Group
255 E. Bonita Ave. Bldg. 1, Suite 101, Pomona Ca 91767
7777 Milliken Ave. Suite 101, Rancho Cucamonga Ca 91730
Ph (909) 593-7437 / Fax (909) 593-0318

Financial Policy

Assignment of Benefits:

I understand that services rendered to me by **Garey Orthopedic Medical Group** are my financial responsibility and that the provider will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to **Garey Orthopedic Medical Group** and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I understand it is my responsibility to pay my estimated copay, deductible and coinsurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim.

I authorize the provider to release any information necessary to adjudicate the claim and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me; I will forward the payment to **Garey Orthopedic Medical Group** within 48 hours. I agree that if I fail to send the payment to **Garey Orthopedic Medical Group** and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.
A photocopy of this Assignment shall be considered as effective and valid as the original.
I authorize **Garey Orthopedic Medical Group** to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Lien/Third Party Insurers:

We are contracted with several government agencies. Under their regulations **Garey Orthopedic Medical Group** **does not** bill third party liability insurance. **Garey Orthopedic Medical Group** **does not** accept lien cases with any legal involvement.

Cancellation of Appointment/No-show Policy:

If for any reason you need to cancel an appointment, please notify our office within 48 hours of the scheduled appointment time. On any second no-show occurrence, there will be a $25 charge to your account. This fee is not covered by insurance. After three consecutive no-show occurrences, the practice may elect to terminate our relationship with you.

Payment
We accept cash, check, Visa, Mastercard and Discover. All returned checks will be assessed a $35.00 returned check fee in addition to the original charge. If you do not have insurance, your balance is due at the time of your visit.

Collections
If your account is unpaid and after three monthly statements or more and you have not responded to any of our attempts to contact you, your account will be referred to a collection agency. Once your account is in collections the practice may elect to dismiss further communication, if no response has been received after multiple attempts. We offer payment plans as a courtesy to our patients in time of need. Payment plans can be arranged with proper communication with our billing department. If you fail to make your scheduled due date, your account will be sent to collections for non-payment.

_____
Printed Name

_____ _____
Signature of policyholder Patient or Guardian

Dated:_____ Witness:_____