Regenerative Medicine and Interventional Orthopedics

Centeno-Schultz Clinic
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FINANCIAL POLICY

Welcome to the Centeno-Schultz Clinic ("CSC"). We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our *Financial Policy* that we require you to read and sign prior to any treatment.

REGARDING INSURANCE

We will gladly bill your insurance company directly if you have provided us with all the necessary information to do so. Your contract for health insurance is between you and your insurance company. We are not a party to that contract. The services that you receive and the bill, is an agreement between you and CSC. **It is ultimately your responsibility to see that your bill is paid in full.** Agreements with insurance companies vary greatly and it is your responsibility to know what their portion is and what is yours. Any remaining money unpaid by your insurance company will be your responsibility to pay in a timely manner. If your insurance company does not begin paying CSC within 5 weeks, it will be your responsibility to contact them. You will be notified by mail of the balance due on your account, and you may request a statement of account if necessary. It will reflect what your insurance company, upon verification, told us is your portion to pay. We expect this payment within 15 days. If payment is not received within this 15-day period, a finance charge of 1.5% will be assessed per month. In the event a check is returned for any reason, a $20.00 charge will be made to your account.

Many insurance companies require a referral from your Primary Care Physician (PCP) to a specialist prior to any appointment. **It is your responsibility to ensure that this referral is obtained prior to all scheduled appointments.** To obtain a referral you will need to contact your PCP and request one. Failure to have a referral on file in our office prior to your appointment will require a waiver and payment in full at the time of service, or for the appointment to be rescheduled.

REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER: All co-pays and deductibles are due prior to treatment. If your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph. If you receive payment made out to both CSC and you, please endorse the check and forward to us.

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 and customary rates. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurances.

PAYMENT FOR SERVICES

Payment is due in full at the time of service for those without insurance coverage. All payment arrangements must be made in advance with the business office at 303-429-6448.

If we bill your insurance and reimbursement is 100% denied, we will bill you our Self Pay rates. If you are unsure of self pay rates, it is your responsibility to ask.

If you are a cash pay patient and you do not pay at the time of service or an arrangement to be billed by our billing department has not been set-up, you will be charged an 18% per annum service charge.

On occasion, certain procedures may not be reimbursed by your insurance company. If it is expected that insurance will not cover, payment is due at the time of service.

Interest is charged on accounts due beyond the grace period. We allow a grace period for 2 months after receiving a final determination from your insurance company or date of service if you are a cash pay payment.

DEPOSITS

All New Patient Evaluations and Follow Up appointments require a non-refundable $50.00 deposit. Our clinic is extremely busy, and we try to keep our waiting list to a minimum. Your deposit will be applied to any future treatment costs or co-ins/deductible or copay.

NO SHOW & LATE CANCELLATION

Our no show/late cancellation policy requires a 48-hour notice if you are unable to make your appointment. If no notice or less than 48-hour notice is provided, there will be a **$50.00 fee** for New Patient Evaluation or follow up visit. **For any procedures,** the clinic must be notified at least 1 week prior to procedure date or The patient will be responsible/forfeiting the Booking Fee paid on all procedures.

I have read the *Financial Policy*. I understand and agree to this *Financial Policy*. I acknowledge the receipt of The Centeno-Schultz Clinic's *HIPAA Notice of Privacy Practices*.

Signed: _____ Dated: _____