DRS. ANDERSON, DELLAMAGGIORE, CHEN, ET AL.
Orthopedic Surgery

PATIENT FINANCIAL RESPONSIBILITY POLICIES

Individual/Group Insurance: As a courtesy to you, we will submit the appropriate claims to your insurance company(s). If your insurance requires an employee claim form, or any other information from you, please submit it to them in a timely manner. Your insurance policy is a contract between you and your insurance company. Therefore, you are ultimately responsible for payment of all charges. It is your responsibility to resolve disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, and use of any special forms. We require that your account be paid in full within 60 days of the date of service, regardless of the status of your insurance claim. If you need an extended payment plan, please contact our **Billing Office at (408) 297-7623**.

Medicare: We are a participating provider and we accept assignment on all Medicare claims. For your convenience, appropriate claims will also be sent to your Medicare Supplemental Insurance. Any deductible, co-payment amounts or routine non-covered services are your responsibility and will be billed to you after Medicare and your supplemental insurance has processed and paid appropriate benefits.

Worker's Compensation: If you are injured on the job, we will process claims to your employer in compliance with California law. If your employer or the employer's Worker's Compensation Insurance Carrier determine that your illness or injury is not related to your employment or is otherwise determined not to be covered by the Worker's Compensation guidelines, than all charges will be your responsibility.

Liability: Services incurred resulting from injury or accident is considered the responsibility of the patient / guarantor. It is your responsibility to ensure that your physician is paid promptly regardless of pending disputed or litigated claims. As we are unable to file claims to a third party insurance carrier, services rendered as a result of automobile accidents must be filed with your personal automotive insurance.

No Insurance Coverage: We require payment for all charges at the time services are rendered. A self-pay discount is offered when payment is made at the time of service. If you are unable to pay at the time of service, please contact our Billing Office to make payment arrangements.

Financial Assistance: We will be pleased to assist you with any questions regarding available payment options. We are committed to providing service to those who may need financial assistance. If you have questions regarding financial assistance or would like a Financial Assistance application, please contact our Billing Office.

If you fail to meet financial obligations agreed upon in this financial policy or other payment arrangements made with this office your outstanding balance will be sent to a collection agency and the complete balance will have to be paid before receiving any further treatment. If you have any questions, please contact the billing department.

Methods of Payment Accepted: Visa, MasterCard, Discover, American Express, cash, and money orders. Payments of co-pays are due at the time of service.

Returned Checks Policy
There is a $25.00 service charge on all returned checks. *After receiving a returned check our office will only accept cash, money order or credit card.

Cancellation/No Show Policy
While understanding there may be times when you miss an appointment due to emergencies or obligations, our office requires at least 24 hours notice on all cancelled appointments. Our office charges a fee of $25.00 for appointments not cancelled or rescheduled 24 hours in advance. Cancellation/no show fees must be paid prior to your next appointment.

Form Completion Policy
There is a fee of $25.00 for all completed forms and is due upon pick up.

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ASSIGNMENT OF BENEFITS

Insurance Authorization / Release: I hereby authorize the physician/provider to release any and all information necessary concerning my diagnosis and treatment for the purpose of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any and all services rendered.

My signature below indicates that I have read and understood the Patient Financial Responsibility Polices of Drs. Anderson, DellaMaggiore, Chen, et al. and authorize the release of medical information as required to process claims and benefits to which I am entitled.

Patient Signature____ Date: ______________

Patient Name (Please Print): ____ DOB:______________

Guardian/Guarantor Signature (if patient is a minor) ____

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