THE SHOULDER CLINIC
OF IDAHO P.L.L.C.

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FINANCIAL POLICY

Thank you for choosing our practice for your shoulder health care. We are committed to giving you excellent medical treatment. The following is a statement of our financial policy that we require you to read and sign prior to any treatment. All patients must complete our "Patient Information Form" before seeing the doctor. Full payment is due for your initial examination at the time of service.

SELF-PAY: Payments on all accounts without insurance are due at the time of service unless you make other arrangements with our Practice Manager.

INSURANCE: Your insurance policy is a contract between you and your insurance company. We do bill all primary insurance for our patients. As a courtesy we will also bill secondary insurances one time.

We will extend credit for 45 days on approved insurance company benefits if such benefits are assigned to the clinic and if the clinic has sufficient information to verify coverage and submit a proper claim. After 45 days if your insurance company has not paid your account in full we require that you pay the balance.

SURGERY: If you require surgery, as part of the pre-operative process we will make an estimate of the professional fees associated with the surgery. This amount is only an estimate. Actual benefits paid may differ due to your insurance company's definition of UCR (Usual, Customary and Reasonable). We require a deposit equal to the amount of your co-pay and deductible or 10% of the estimate of professional fees, whichever is less. This deposit is due before or upon the day of your surgery.

UNPAID ACCOUNTS & INTEREST CHARGES: All unpaid accounts for which payment arrangements have not been made are subject to collection procedures. Any costs incurred in the collection of those accounts are added to the accounts. We charge interest on all unpaid balances that are over 90 days past due from the date we provided services to you, and refer these balances for collection. We reserve the right to charge interest at the rate of 1 1/2% per month, 18% annually.

CREDIT OPTIONS AVAILABLE THROUGH THE CLINIC:

We accept:
- Three equal payments within 90 days from the date of service without interest
- Cash
- Personal Checks
- Visa and MasterCard Credit Cards
- Local Debit Cards

I HAVE READ, UNDERSTAND, AND AGREE TO COMPLY WITH THIS FINANCIAL POLICY.

Date:_____Name: _____
PRINT NAME OF PATIENT

X_____
SIGNATURE OF PATIENT/RESPONSIBLE PARTY