

## **FINANCIAL POLICY**

Thank you for choosing Action Brace and Prosthetic, Inc. as your health care provider. We appreciate the opportunity to serve you. The following is a statement of our Financial Policy, which we ask you to read and sign prior to treatment.

### **Payment for services provided**

Payment is due at time of service. We accept Cash, Checks, Debit and all Major credit cards.

### **Regarding Insurance**

Action Brace and Prosthetic agrees to bill most insurance carriers, if all necessary information is provided. Should your insurance not cover the services provided, the balance is your responsibility. If your insurance company has not paid your account within 90 days, the balance will be automatically transferred to your responsibility. A statement will be mailed to you and payment is expected upon receipt.

Your insurance policy is a contract between you and your insurance company. Coverage cannot be guaranteed. Estimates that we provide are based on an insurance verification done prior to delivery of your device. You will need to contact your insurance carrier with any problems or questions.

Please note, some and perhaps all of the services provided may be NON-COVERED services under the Medicare program, and/or other medical insurance. In this instance a statement will be mailed to you and payment is expected upon receipt.

### **Giving Approval**

Once you give approval for your custom made device. You and your insurance are financially responsible whether or not you choose to be fit with the product.

### **Usual And Customary Rates**

It is our policy to charge our patients and their insurers in a fair and consistent manner. Our fees are set at usual and customary rates for this area.

### **Returns**

Since the device is custom fabricated and prescribed by the physician, it cannot be returned for credit on the account. Prescribed "off the shelf" items cannot be returned for credit because of hygienic concerns.

### **Minor Patients**

The adult accompanying a minor is responsible for payment. If the minor is unaccompanied he/she should have payment with them, or prior arrangements should be made.

### **Returned Checks**

Should you make payment by check and it is returned, a fee of \$15.00 will be charged to your account.

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Signature of Patient/Responsible Party

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Date