FINANCIAL POLICY

Thank you for choosing James M. Grimes MD Orthopedics to meet your medical needs. We are committed to providing you with the best treatment available. The following is a statement of our Financial Policy, which we request that you read and sign.

Co-pays and payment for services are due at the time services are rendered. For your convenience, we accept cash, checks, and major credit cards.

Returned checks will be charged a twenty- five dollar ($25.00) handling fee. Balances over thirty (30) days will be subject to a handling charge of five dollars ($5.00). A minimum charge of twenty-five dollars ($25.00) will be made for missed appointments and appointments cancelled less than a twenty-four (24) hour advance notice.

If you have insurance, we will help you receive your maximum allowable benefits; however you remain responsible for your co-pay and for payment if your claim is rejected. Sixty (60) days from the date of service is a reasonable amount of time for the insurance company to make a decision as to whether they will pay any of your bills. You will be responsible for the entire bill that has not been paid within the sixty (60) day period.

If you have any questions concerning your account, please feel free to ask our patients receivable coordinator.

I hereby confirm that I have read the above payment policy and agree to accept it.

Patient:

(Signed):_____

(Please Print):_____

Date: _____

EXTENDED PATIENT FINANCIAL RESPONSIBILITY POLICY

James M. Grimes MD Orthopedics agrees to provide an **EXTENDED FINANCIAL PLAN** to _____ (patient), to assist with your payment of the unpaid balance of $_____ to avoid sending this unpaid balance to the **COLLECTION SERVICE** used by our practice

The balance of $_____can be paid today by cash, check or credit card to clear this account.

Your account balance may also be paid to James M. Grimes MD Orthopedics by submitting monthly payments of $_____ for _____months due by 10th day of each month.

If payments are not received by the above date agreed upon for two (2) consecutive payments, then the full amount will become due and payable by the following payment date, and your account will be submitted to our **COLLECTION SERVICE**, if these terms are not met.

PATIENT

Signed: _____

Please Print: _____

Date: _____

For *several months* you have been receiving a statement from our office concerning your balance of $_____that you owe the practice for services that were provided to you.

For some reason, you have failed to respond to these statements. Our consulting firm has recommended that we send you this letter to give you one last chance to respond.

Please see that the balance is paid in full within the next fifteen (15) days and we will be able to continue to provide you with medical services. If you are having difficulty paying your balance and need to make payment arrangements, please call the office at (phone number)and ask for_____.

If you choose to ignore this letter, we will have no other choice but to consider collection actions which could impact your credit rating. Your decision not to respond could also impact our ability to continue to see you as our patient.