



FINANCIAL RESPONSIBILITY POLICY

It is the policy of this office that all patients, or their guarantors are financially responsible for the services provided by Orthopedic Associates of SW Ohio. We expect co-pays to be paid at the time of service. The office asks that all patients assign all insurance company payments directly to the practice to avoid any misunderstandings regarding payment for professional services. The patient will be responsible for any portion of his or her bill that is not covered by the insurance carrier. If your insurance requires that you have a referral from your Primary Care Physician, it is your ultimate responsibility to ensure that our office receives that referral before your visit. If that is not done, you will be responsible to pay for the provided services. We accept Visa and MasterCard. If you need to set up a payment plan, please talk to our billing department.

Again, thank you for your understanding and cooperation with this policy.

I do hereby understand and agree with the financial policy of Orthopedic Associates of SW Ohio.

Date: _____

Signature of Patient: _____

Guarantor (if necessary): _____

Relationship to patient: _____