Alta Orthopaedic Patient Payment Policy

We are committed to the success of your medical treatment and care. Please understand that a mutual financial understanding is a part of our relationship. Thank you for choosing Alta Orthopaedics for your orthopedic care.

We have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies please a Billing Specialist.

What type of payments are accepted? *We accept payment by cash, check, VISA, MasterCard and CareCredit, American Express and Discover.*

We participate in some health plans: *If you are Tricare, Medi-Cal, MIA, CENCAL, Tribal Health, Sansum Clinic, Santa Barbara Select IPA you need authorization to be seen. If we do not receive HMO authorization prior to your arrival at the office, your appointment will be rescheduled. Please call your plan's customer service department to verify if we are contracted providers.*

Your financial responsibility for office visits and services depends on a variety of factors:
The patient responsibility is dependent on all applicable co-pays, co-insurance and deductibles for services provided at the time of the office visit. There may also be a yearly deductible or cap on some services. Our office files an insurance claim as a courtesy to you. For non-covered services payment in full is the responsibility of the patient.

Point of Service Plan or Out of Network PPO: *There may be higher out of pocket expense, which includes deductible, co-pay and co-insurance.*

Medicare: *As of 01/01/2008, we are participating providers in Medicare. Per Medicare rules we will ask you to sign a Medicare ABN form (Advance Beneficiary Notice of Noncoverage) for services not covered by Medicare.*

If you have Medicare Advantage or Medicare C plan, this gives the beneficiaries the option to receive benefits through private health insurance plans. These Private Fee for Service (PFFS) plans vary and you should call the customer service line to clarify your co-pay, co-insurance and deductible amounts.

No Insurance: *Payment in full is requested at the time of the visit***.**

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- *I have read, understand and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments, co-insurance and deductibles, are my responsibility.*
- *I authorize my insurance benefits be paid directly to Alta Orthopaedics.*
- *I authorize Alta Orthopaedics to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.*
- *I understand there is a $45 charge if I do not call and cancel my appointment one business day prior to the time scheduled.*

DATE:_____ SIGNATURE:_____