

CALIFORNIA ORTHOPAEDIC SPECIALISTS

360 San Miguel Drive, Suite 701
Newport Beach, California 92660
(949) 759-3600
FAX (949) 759-5017

Ralph J. Venuto, M.D.
Michael P. Weinstein, M.D.
Scott K. Forman, M. D.

Nicholas E. Rose, M. D.
Stephen A. Mikulak, M. D.

Patient Financial Agreement

Dear Patient or Guardian:

Our goal is to provide you with the best medical care available. A clear understanding of our financial arrangements is essential for a successful doctor/patient relationship.

We are contracted with most PPO insurance plans. We do not accept any HMO, IPA, MediCal, CalOptima, MSI plans, MultiPlan, Beech Street or Health Net. Dr. Forman and Dr. Mikulak are not Medicare providers.

Our office will verify insurance eligibility and benefits, however we cannot be held responsible for information received when verifying insurance benefits since it is not a guarantee of payment or eligibility. Please call your insurance for detailed information regarding your plan. **Ultimately, your insurance is an agreement between you and your insurance company.**

Please do not ask for discounts, waiving your co-payment or insurance only as this violates our contracts with your insurance.

If you do not have insurance, you will be expected to pay for your services at the time they are rendered unless prior arrangements have been made. We accept cash, check, MasterCard, American Express and Visa.

Charges for your treatment will be billed to your insurance company. However, if your insurance company has not paid their portion of the charges within 60 days, the account will revert to your responsibility. If there is a major discrepancy between our fees and your insurance carrier's allowance, our office will assist you in providing your insurance company with additional information as needed for your claim to be reprocessed. While your claim is in review, a monthly payment plan will be implemented for you.

Returned checks will be charged \$25.00 and you will no longer be able to write checks for services in the office.

My signature below indicates that I have read and understand the above statements. I have received a copy of this agreement for my records.

Signed Patient/Guarantor: _____ Date: _____

Witness _____ Date: _____