VIPO
Valley Institute of Prosthetics and Orthotics, Inc.

PATIENT NAME: ____

FINANCIAL POLICY

Thank you for choosing Valley Institute of Prosthetics & Orthotics. We are committed to providing you with the best possible care and successful treatment. Your clear understanding of our financial policy is important to our professional relationship. *Please read this information carefully* and let us know if you have any questions.

Medical Insurance

If you have medical insurance we will be happy to submit a claim for you if all required information is provided.

- *Payment by insurance is based on your eligibility for coverage on the date of delivery (the date you actually receive your item).*
- We cannot guarantee payment of all claims. Your insurance is a contract between you and your insurance company and it is important that you understand the coverage your policy provides.
- Some services, even though ordered by your doctor, may be "non-covered" or considered "medically unnecessary" under Medicare or other insurance programs and *you will be responsible for payment of the full price of the item.* Reduction or rejection of your claim by your insurance company does not relieve you of your financial obligation.
- **If you have a managed care or PPO medical insurance plan** that we participate with, your payment of deductibles, non-covered services and co-payments are due when services are rendered.
- **If you are covered by Medi-Cal,** you must present your *current month* Medi-Cal card *prior to services being rendered*. If we are otherwise unable to verify your eligibility, services will be considered self-pay, and you must pay at the time of service.

Late Fees and Collection

- All amounts that are more than 30 days past due will be subject to finance charges of 1.5% per month.
- Accounts more than 60 days past due may be sent to collection.
- Any check returned unpaid by your bank is subject to a $25 service fee.

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I have read and understand the VIPO Financial Policy as outlined above and I agree to its terms.

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Patient or Responsible Party Signature | Date Signed

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Patient or Responsible Party Full Name (Please print clearly)

Thank You. Please let us know if you have any questions or concerns.