Samotin Orthopaedics
9240 Bonita Beach Road, Suite #2200
Bonita Springs, Fl 34135
Tel: 239-514-4200

Credit Card Financial Policy

Samotin Orthopaedics is happy to file your **Primary Insurance** claim as required by our PPO contracts. Deductibles/co-pays and other non-covered services are collected at the time medical services are provided. Please be advised that verification of insurance benefits and coverage are not a guarantee of payment. It is our policy to maintain a copy of your credit card and your consent to charge for balances. **Often times additional co-pays, deductibles, co-insurance, non-covered services and limitations within your health insurance policy are not disclosed at the time benefits are verified**; subsequently, resulting in additional balances that will be charged to your credit card we have on file when we receive you insurance company's notification. You as well receive a notification every time our office receives one. **Please sign: _____**

As for **Secondary Insurances,** we are happy as a courtesy to file a claim on your behalf, however, Samotin Orthopaedics is **neither required nor mandated to file secondary claims.** If your secondary claim is not paid within 45 days, Samotin Orthopaedics will then charge your credit card for the remaining balances. Remember, secondary claims may have applicable deductibles and co-pays as well.

SAMOTIN ORTHOPAEDICS WOULD LIKE TO REMIND YOU THAT YOUR HEALTH INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY ONLY. IT IS YOUR RESPONSIBILITY THAT YOU CALL AND VERIFY BENEFITS AND COVERAGE WITH YOUR INSURANCE COMPANY SO THAT YOU ARE AWARE OF YOUR RESPONSIBILITY. WE ARE NOT RESPONSIBLE FOR WRONG INFORMATION PROVIDED BY YOUR INSURANCE COMPANY.

I,_____ completed this form and I authorize Samotin Orthopaedics to make photo copy of my credit card (listed below) to serve as an irrevocable authorization to charge this credit card to cover any balances as described above. I also acknowledge that it is my responsibility to update Samotin Orthopaedics if my credit card information changes. By signing below, I further acknowledge full financial responsibility in the event my credit card does not satisfy my outstanding balance; I also acknowledge if any unpaid balances are require referral to a collection agency/lawyer, I would also be responsible for additional fees; which include late payments charges, collection agency fees and legal charges.

_____ Visa _____ Amex _____Discover

My credit card #: _____ Exp. Date_____/_____/_____ Sec. Code: _____

Patient/Guardian Signature: _____ Date: _____/_____/_____

Print Your Name: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____