Dirk R. Diefendorf, M.D.
ORTHOPEDIC SURGERY - SPORTS MEDICINE

INSURANCE INFORMATION-BILLING & COLLECTION POLICY

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN. YOU MAY REQUEST A COPY OF THIS FORM FOR YOUR RECORDS.

MEDICARE PATIENTS: Dr. Diefendorf accepts Medicare Assignment. We will bill Medicare for you and accept the Medicare Allowable amount.
If you have secondary insurance of any kind, we will bill them for you after receiving payment from Medicare. You will be responsible for charges and services NOT covered by your insurance.

CONTRACT (Participating Provider) PLANS: We will bill your insurance for you. You will not receive a bill from us until after your insurance has responded to our billing. Please be sure to notify us of any change in your insurance coverage. Your co-pay if any, will be due at each visit.

NON-CONTRACT PLANS: If you have provided us with an insurance card and claim form we will be happy to bill for you. If you do not have insurance, if we are out-of-plan physicians, or if this is a third party claim (i.e.: auto accident or slip and fall) you must pay for services at the time of your visit. Payment methods accepted are cash, check or credit card.

MEDICAL INFORMATION RELEASE: I authorize by my signature below, release of my medical information necessary to insurance companies for processing claims or to other physicians for second opinions, etc.

INSURANCE ASSIGNMENT: I hereby assign payment by my insurance company to be paid directly to Dirk R. Diefendorf, M.D. I understand that I will be reimbursed for any insurance overpayment to my account.

A photocopy of this release and/or assignment shall be considered as valid and as effective as the original. I understand that should my account be sent to collection, any collection fees and/ or attorney fees and court costs associated with settling my account shall be added to my account balance.

BILLING AND COLLECTION POLICY: I understand that a finance charge of 1.5% per month may be charged on balances 30 days past due. I understand that I am responsible for all charges incurred regardless of any insurance which are 90 days or more past due. I also understand that a fee of $35.00 will be charged for each check returned for insufficient funds.

I HAVE READ, UNDERSTAND AND AGREE TO ALL OF THE ABOVE.

Patient Name:_____

Signature:_____ DATE:_____
(Parent Signature if patient is a minor)