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Phone: 303-321-1333
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Financial Agreement

Western Orthopaedics, P.C. is proud to provide exceptional quality orthopaedic care to our patients. In order to do this we must be fiscally responsible. Please read our financial agreement and sign and date below.

- I understand that it is my responsibility to provide accurate and updated insurance information at the time of scheduling my appointment. If **any information** has changed from a previous appointment, it is my responsibility to update Western Orthopaedics. This will avoid insurance payment denial and therefore avoid potential personal out of pocket expense that I may incur for denied charges.
- I have checked with my insurance provider and understand my benefits, plan coverage and out of pocket expenses including copays, deductibles and covered procedures.
- I understand that copays, deductibles and services not covered by insurance must be paid prior to the service being rendered. Western Orthopaedics accepts cash, checks, debit cards, MasterCard, Visa, Discover and HSA cards.
- I understand that there will be a $30 service fee on all return checks.
- I understand that if I do not provide my insurance card, referral information or pay the required copay/deductibles or outstanding balances, that my appointment will be rescheduled until I can provide the above-mentioned information/payments.
- I understand that if I am a self-pay patient, a $350 fee will be collected prior to seeing the physician. If the amount of the office visit exceeds the $350 pre-payment, I will be responsible to pay the difference prior to leaving the clinic. If less, you will be refunded.
- I understand that some surgical procedures performed may require some kind of pre-payment prior to scheduling the procedure. The cost estimate will be given to me by the physicians scheduling party. If I would like to proceed with scheduling the procedure I understand the estimated amount is due at that time and I may be billed for additional charges once insurance has paid.
- I understand in some instances, a payment agreement may be made prior to services rendered. Western Orthopaedics typically asks that all balances be paid in full within 90 days from date of service.
- I understand that I may be contacted by phone, email or letter form regarding any outstanding balance with Western Orthopaedics, P.C.
- I understand that Western Orthopaedics. P.C. will bill my insurance as a patient courtesy. As the patient, I am ultimately responsible for the payment of all professional fees. If I have not paid all balances within 90 days of rendered service, and no arrangements were made prior to these services being rendered, it is possible my account may be placed with an outside collection agency and no additional appointments (other than urgent/emergent appointments or if you are within your post op period) will be made until the account has been brought current.

- I understand that if my account is turned over to an outside collection agency, Western Orthopaedics, P.C., will provide the collection agency with an itemization that contains healthcare information necessary for collection of their services rendered (i.e.: procedure codes, diagnosis codes and body part). I will be responsible for all attorneys' fees, court costs, other legal fees, collection agency fees, and cost incurred in collecting my medical payment, together with late fees and interest. I also understand that the collection agency notifies the credit bureaus on any collection balances not paid, in full, within 30 days of receipt.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE POLICY.

Name of Patient:____

Patient Date of Birth:____

Signed: ____Date:________________________

Patient or guardian signature

____

Relationship to Patient

RELEASE OF INFORMATION:

I hereby authorize release of any information acquired in the course of my examination or treatment to my insurance carrier.

Signed: ____ Date:________________________

Patient or guardian signature

RELEASE OF BENEFITS:

I hereby authorize my insurance benefits to be paid directly to Western Orthopaedics, P.C.
I understand I am responsible for all non-covered services.

Signed: ____Date:________________________

Patient or guardian signature