WESTERN ORTHOPAEDICS
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FINANCIAL AGREEMENT

Western Orthopaedics, P.C. is proud to provide exceptional quality orthopaedic care to all patients. In order to do this, we must be fiscally responsible. Please read this financial agreement. Your signature indicates you have read and understand the terms of the agreement.

- 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 previous appointments, it is my responsibility to update Western Orthopaedics. This will avoid any insurance denials and reduce unnecessary out-of-pocket expenses that may occur for denied charges.
- I have checked with my insurance provider and understand my benefits, plan coverage, and out-of-pocket expenses including copays, deductible, covered and non-covered procedures.
- I understand that copays, deductibles and services not covered by your insurance must be paid prior to the services being rendered. Western Orthopaedics accepts cash, checks, debit cards, MasterCard, Visa, American Express, Discover, HAS cards and money orders.
- I understand that there will be a $30.00 service fee applied to all returned checks.
- I understand that if I do not provide my insurance card, referral details or pay my copay or other outstanding balances, that my appointment may be rescheduled until I can provide the above-mentioned information/payments.
- If I am a **SELF PAY** patient (not having health insurance or desire to not have your health insurance billed) the following fees will apply:

  $350 - New visit evaluation & management service (with or without x-ray.)

  $250- Established patient follow up visit (with or without x-ray.)

  $100- Postoperative patient visits with x-ray

  The above fees need to be paid on or before the appointment date.

- I understand that there are several surgical procedures that may require a pre-payment prior to scheduling the procedure. The estimate of cost will be given to me by the providers' office staff. If I would like to proceed with scheduling the procedure, I understand that a portion of the estimate is due prior to the service. I understand that I am ultimately responsible for my bill.
- I understand in some instances, a payment agreement may be made prior to services rendered. Our current policy allows payment plans if paid-in-full within 90 days.
- I understand that I may be contacted by phone, email or letter form regarding any outstanding balances.
- I understand that Western Orthopaedics, P.C. will bill by 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 outstanding balances within 90 days from the date of service, my account may be placed with

an outside collection agency and no additional appointments (unless emergent/urgent or related to recent surgery) will be made until the account is paid.

- I understand that If my account is turned over to an outside collection agency, Western Orthopaedics will provide the collection agency with demographic and financial information necessary for collection. I understand that I will be responsible for all attorney's fees, court costs, other legal fees, collection agency fees. late fees, interest, and other costs incurred in collecting payment.
- I understand that the collection agency may notify the credit bureau on any unpaid collections if not paid in full within 30 days of receipt.

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

Name of 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