Name

Chart

Date

ALPINE ORTHOPAEDIC SPECIALISTS
FINANCIAL POLICY

Thank You for choosing Alpine Orthopaedic Specialists as your Health Care Provider. We are committed to giving you excellent medical treatment. The following is a statement of our financial policy that we require you to read and sign prior to any treatment. All patients must complete our "patient information forms" before seeing the doctor.

CONSENT TO TREAT: I consent to treatment at Alpine Orthopaedic Specialists for services or supplies that have been or may be ordered by the physician. I understand that treatment may include but is not limited to; radiological examinations, injections, laboratory procedures, physical therapy, nursing care, braces, orthotics, crutches, or medical and surgical treatment. I acknowledge that the clinic has not made nor can it make a guarantee of the outcome of treatment.

SELF PAY: Payments on all accounts without insurance are due at the time the service is rendered and will be charged at our self pay fee schedule amount. Monthly budget plans are available if arrangements have been made with the business office and Self Pay Financial Policy has been completed.

INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to our patients, we will submit claims to your insurance carrier if you have provided us with all the pertinent information to process a claim. We will extend credit for 60 days on approved insurance company benefits if such benefits are assigned to the clinic and if the clinic has sufficient information to verify coverage and submit a proper claim. After 60 days if your insurance has not paid your account in full, we require that you pay the balance. You are also responsible for all deductibles, co-payments, and charges not covered by insurance. I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

LIABILITIES: Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations; this is your responsibility. We will extend credit for 60 days on liability accounts only if we have the necessary information to exercise our third-party rights. If you cannot provide this information, your account is due at the time of service. If your claim has been denied or benefits exhausted the balance is your responsibility and payment in full is required at that time. If your claim is settled and made payable to us any overpayment by you will then be refunded.

CONTACT OPTIONS: We want to stay in touch with you regarding your account and its collection status regarding past due balances. In order for us to contact you regarding all past due accounts and any collection status they may have, you expressly authorize us to contact you by the telephone by sending text messages or e-mails at any number or email you have listed. You acknowledge that such contact could result in charges to you by your telephone carrier. Methods of contact may include the use of pre-recorded/artificial voice messages and/or the use of an automatic telephone dialing system, as applicable. You acknowledge and agree that this authorization shall extend to any billing or collection company or companies which may be assigned.

Yes, I authorize this (initials) _____ No, I do not authorize this (initials)_____

UNPAID ACCOUNTS & INTEREST CHARGES: In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agrees to pay all collection agency fees, court costs, and reasonable attorney's fees incurred. If the account must be referred to an outside collection agency, and you have opted out of receiving a final notice for the delinquent account by text or email, a letter via certified mail or priority mail will be sent. In sending this letter, a fee of up to $6.00 will be added on top of the 25% collection fee when the balance is reported. We reserve the right to apply a monthly finance charge of 18% annual interest per date of service, for missed payments on delinquent accounts.

CREDIT OPTIONS AVAILABLE: We accept VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, and DEBIT CARDS.

I acknowledge that I have reviewed the notice of Privacy Practices which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request. (initials) _____.

*****I HAVE READ, UNDERSTAND, AND AGREE TO COMPLY WITH THIS FINANCIAL POLICY*****

PATIENT NAME (please print)	**DATE**
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY	**PRINTED NAME**

In Case of Emergency Please Contact:

Name	**Phone**	**Relationship**
Name	**Phone**	**Relationship**
Name	**Phone**	**Relationship**