

FRONT RANGE ORTHOPAEDICS FINANCIAL POLICY

Welcome to our office! We are pleased you have chosen Front Range Orthopaedics to provide your care and service. We would like to take a moment of your time to inform you of the policies regarding payment with our office.

We accept cash, personal checks, Visa or MasterCard for payment of your account. If you have no insurance, or have insurance, which we do not contract with, you will be expected to pay for your visit in full, on the day of your visit. If your insurance is one we do contract with, you are expected to pay your co-pay at the time of your visit.

NO INSURANCE: If you have no insurance, we expect you to pay for your visit at the time of service. In the event of surgery, our Financial Advisor can help answer questions about possible financial sources.

MEDICARE: We are Participating Medicare Providers. We will submit your insurance to Medicare. Medicare will process the payments to us. You will be responsible for your deductible and any co-insurance at the time of service.

MEDICAID: We do participate with the Medicaid program. You must provide us each month with a copy of your Medicaid card indicating that you are still eligible for Medicaid. Should services be rendered, and you are no longer eligible for Medicaid coverage, you will be responsible for payment based on our normal fee schedule. All co-pays are to be paid on the day of service.

CONTRACTED INSURANCE: If you have insurance we do contract with, (this may be verified from your insurance book given to you by your employer or agent) we will submit your insurance claims for you if you supply us with the information necessary to do so. This includes a copy of your card, and address to submit claims to and a telephone number allowing us to verify your coverage. You still are responsible for payment of your co-pay at the time of service, and any amounts not covered by your insurance, including deductibles. If coverage is denied for any reason, you are responsible for payment of the entire balance due, based on our normal fee schedule.

PRIVATE INSURANCE: As a courtesy we will be happy to file your insurance for you. You will be required to provide all the necessary billing information. If you owe on your deductible or owe a co-insurance we will need to collect that at the time of service. All insurance payments that are paid directly to you should be endorsed and paid to the physician. It is your responsibility to contact your insurance in the event of non-payment. Many private insurance companies in an effort to set physician fees restrict payment indicating that fees are over the "Usual and Customary" fees for this area. We have hired consulting firms to ensure that our fees are comparable to that of other offices providing the same quality of care. We will not allow insurance companies to set our fees for us, based on their ability or willingness to pay.

WORKERS COMP/AUTO INSURANCE: If your visit here involves an accident related injury, we must know the date of the accident, where the accident occurred, and the name and telephone number of the adjuster for your case. We cannot bill your regular health insurance for accident related injuries. If this information is not provided, or your case is denied for payment for any reason, you are responsible for payment of the entire balance due based on our normal fee schedule.

NON-PAYMENT: In the event your account becomes delinquent, you will be responsible not only for charges incurred, but also any costs involved in collection of your account. These include, but are not limited to, interest charges, rebilling fee, court costs, attorney fees and collection costs. Insurance coverage is a matter between you and your insurance company. You are ultimately responsible for the payment of your account.

If you have any questions regarding our payment policies, please ask us before your visit. Thank You.

I have read and understand the payment policies set forth, and have been given the opportunity to ask question about this policy. I understand my responsibility for payment of my account with Front Range Orthopaedics and have provided to the best of my ability the information requested accurately and completely.

X _____ Date
Signature Required (Responsible Party Over 18 Years of Age)