PATIENT FINANCIAL INFORMATION

We find that our clients appreciate knowing in advance what is expected of them financially and what terms and conditions are available. Please read the following information carefully. If you should have any questions, please direct them to our Office Manager.

Patient Payment: As a condition of treatment by this office, all fees must be paid at the time the service is provided. Payment may be made by cash, check and most credit cards. Any other payment arrangements must be authorized in advance by our Office Manager.

Insurance: For most patients who carry insurance, similar terms apply. You must provide an insurance card for billing information. As a courtesy, this office will file a claim for your treatment with your insurance company and will accept assignment of benefits providing you pay all patient deductibles and estimated percentages at the time of your visit. We accept no responsibility in collecting overdue insurance claims or negotiating settlement on disputed claims. You are responsible for the total charges or any difference remaining following payment by your insurance company. If your insurance has not made payment or you feel that your insurance company has not made correct or adequate payment on your account, you must contact them first to discuss the matter. Please request that your insurance company provide you with a confirmation number as record of your follow-up with them. We will not resubmit claims until this has been done.

Your insurance company is required by the Colorado Insurance Commissioner to process, pay or reject all insurance claims within 30 days. We guarantee accurate filing based on the information you provide to us. On day 31, if your insurance company has not reimbursed our office, you are responsible for payment in full of your balance. Balances not paid within 60 days will be subject to collection.

Appointment Commitment: When we schedule an appointment for you, two events occur: 1) We will hold that appointment time for you in our appointment book and, 2) We trust you will arrive on time for that appointment. If you are late for an appointment, we will do our best to fit you into our schedule; however, it may be necessary for us to reschedule your appointment. Our policy is that the first time an appointment is missed or cancelled with short notice, a reminder letter is sent out. The second time this occurs, you will be charged a fee of $25.00. If subsequent appointments are missed or cancelled with short notice, you may be discharged from our practice. We do not allow repeated cancellations or short notice changes as this puts our partnership with you in jeopardy.

In consideration of the professional services rendered to me, I agree to accept responsibility for the payment of such services, and I agree to pay all legal costs including collection fees and attorney fees if I fail to pay my account. I grant permission to you or your assigned, to telephone me at home or at my work to discuss matters related to this form. I have read and agree to the above conditions of treatment.

____________________________ (Signature of Guarantor/Patient)

____________________________ (Printed Name of Patient if different than Guarantor)

____________________________ (Printed Name of Guarantor)

____________________________ (Date)