Patient Financial Responsibility/ Insurance Acknowledgement & Authorization

Thank you for choosing **Western Slope Orthopaedics** as your healthcare provider. We are honored by your choice and committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

- The patient is ultimately responsible for the payment of his/her treatment and care.
- The patient is responsible for charges associated with Insurance co-pays or non-covered charges such as deductible or coinsurance amounts.
- Self-pay patients are eligible for a cash discount of 30% up to 30 days after the date of service seen.
- The patient is responsible for any costs associated with collections of patient balances.
- Patient statements are mailed monthly. The patient is responsible for making a payment, or for arranging a payment plan, within 30 days of the date that appears on his/her patient statement.
- The patient is aware that failure to pay for his/her treatment and care will result in collection actions being taken to collect the debt (i.e. being sent to a collection agency)

You are responsible for supplying your own personal insurance, or work comp/auto information to our office. If you do not give us your information, **you** will be responsible for all charges incurred and payment will be expected at the time of service.

I request that payment of authorized insurance benefits be made on my behalf to Western Slope Orthopaedics for any services rendered to me by C. Kelly Bynum, M.D., Thomas F. Dwyer, M.D., Timothy R. Judkins, M.D., Ryan K. Albrecht, M.D, Joshua Bagley, M.D, Jared Sanderford, D.O. and Vineet Singh, M.D. I authorize any holder of medical information needed to determine these benefits payable for related services rendered. I understand that I am responsible for any amount of my charges **NOT** covered by my insurance. All information on this form is true to the best of my knowledge. I agree to the information stated above. A photocopy of this authorization shall be considered as valid as the original.

By my signature below, I hereby authorize the assignment of financial benefits directly to Western Slope Orthopaedics. I understand that I am financially responsible for charges not covered by this assignment.

Signature of Patient or Guardian: _____ **Date:** _____

Name of patient: _____