



PAYMENT POLICY

The billing process and the mailing of statements is a very expensive process. We can all cooperate to keep the cost of your medical care under control. If Vail-Summit Orthopaedics is not contracted with your insurance company, charges for medical services are to be paid at the time service is rendered. We will file contracted insurance as a courtesy. Otherwise, we will provide you with information necessary for you to file your claim with your own insurance company. Any unpaid patient balance will accrue a 1 ½% monthly billing charge after 90 days. Any collection fees, attorney fees, or returned check fees are the responsibility of the adult person(s) named on the account.

In addition, I assign directly to Vail-Summit Orthopaedics all surgical and/or medical benefits, if any, otherwise payable to me for services rendered.

I understand that if I have not listed any insurance above, or if the insurance I have listed is not contracted with Vail-Summit Orthopaedics, that I am responsible for the full amount of the visit at the time the service is rendered.

I also verify that all the information contained on these information sheets is true and correct, to the best of my knowledge and belief. I authorize Vail-Summit Orthopaedics to release my complete records to my insurance company in order to process my claim and to or from other physicians or medical facilities that may be pertinent and necessary to care and treat. I also authorize Vail-Summit Orthopaedics Designation of Representation for insurance claims appeals.

*****For complete financial policy information please contact our Billing Office at 1-866-358-0202*****

CONSENT FOR TREATMENT

I hereby give consent to the physician and staff of Vail-Summit Orthopaedics to render such care and treatment as might be required by my condition. Such care can include, but is not limited to diagnostic procedures such as laboratory and imaging, examinations, rehabilitation, medical and/or surgical treatment and injections.

Print Name _____

Signature _____ **Date** _____

If patient is 17 years of age or younger please indicate relationship: _____

Patient's Name _____

WORK RELATED INJURY INFORMATION

(Complete this section only if injury occurred at work)

Employer Name _____ **Supervisor** _____

Employer address _____ **Employer phone#** _____

Employer Worker's Compensation Insurance Company _____

Treatment authorized by _____

Date of injury _____ **Body part injury** _____ **Claim Number** _____

Colorado Worker's Compensation Law states that "If injured on the job, written notice must be given to your employer within four working days of the accident." If for any reason this claim for worker's compensation is declared fraudulent or determined not to be compensable, or if I fail to report this injury within four working days to my employer, I, _____, hereby agree to pay for all services rendered.

Signature _____ **Date** _____