

Steadman Hawkins Denver Clinic

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that I am responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred. I understand that I am responsible for payment of outpatient office charges at the time of the visit, unless other arrangements have been made. The Steadman Hawkins Denver Clinic will bill my insurance, provided all of the necessary information is given to the clinic. If any insurance company does not submit payment within 45 days, I understand that I will be responsible for any outstanding balance. I understand the Steadman Hawkins Denver Clinic will bill my insurance for any surgical charges, though I will be required to provide a deposit prior to the surgery based on an estimated financial responsibility.

NOTICE OF "NON-COVERED" SERVICES

I am aware that my insurance carrier or Medicare may consider some services performed by the Steadman Hawkins Denver Clinic "non-covered", therefore I will become fully responsible for payment of these services.

WAIVER OF "USUAL, CUSTOMARY AND REASONABLE" CLAUSES

(For patients with "UCR" coverage) I acknowledge that the fees charged by Steadman Hawkins Denver Clinic for services rendered to me, or to the person for whom I assume financial responsibility, may exceed the fees considered "usual, customary and reasonable," due to specialized services and staff. However, I agree to pay fees in full, even if the amount is greater than what I am reimbursed for from my insurance company.

BILL TO/PAYMENT INSTRUCTIONS

Initial

I hereby authorize and request the Steadman Hawkins Denver Clinic to bill my insurance company for all services provided to me. I also authorize payment of medical benefits to the Steadman Hawkins Denver Clinic for any services provided to me and billed by the Steadman Hawkins Denver Clinic.

PERMISSION TO RELEASE MEDICAL INFORMATION

I authorize the Steadman Hawkins Denver Clinic to release information from my medical record, or from the medical record of the person for whom I am legally responsible, to my/their insurance company, other third-party payers or their reviewing agencies. This information must be limited to that which is necessary to expedite claim processing. This authorization is valid for every visit to the Steadman Hawkins Denver Clinic or its affiliates until written notice revoking it is provided.

I release the Steadman Hawkins Denver Clinic of all responsibility for loss of confidentiality through access and or copies made of records released in compliance to this authorization.

I have read all of the above and understand/agree to all provisions therein regarding responsibility for payments and release of information.

Patient's Name _____

Patient's or Legal Guardian's Signature: _____ Date _____

If Legal Guardian, Relationship to Patient _____