ROCKY MOUNTAIN SURGICAL ASSOCIATES, P.C.
FINANCIAL POLICY

Our practice is committed to providing the best treatment for our patients. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

- We accept cash, checks, or MasterCard/Visa/Discover.
- **We do NOT participate with the Colorado Indigent Care Program (CICP).**
- All payments must be received in **full** within 3 months, or your account will be turned over to our collection agency. Any collection fees, court costs, reasonable attorney fees, or returned check fees are the responsibility of the adult person(s) named on the account. A monthly service fee of 1.5% per month or 18% per annum will be assessed on all past due counts by the collection agency.
- In addition to our physician charges, you may receive bills from other entities such as: Hospital, assistant surgeons, surgical facility, anesthesiologist, pathologist, radiologist, and diagnostic laboratories. We do not know what these charges will be.
- In some cases a surgical assistant is necessary. At the time you schedule surgery, check with the surgical scheduler to see if this is a benefit provided by your insurance carrier.

Self-Pay Patients

Patients without insurance coverage will be required to pay in full at the time of their office visit/office procedure. A patient requiring hospital surgery will need to pay in full 5 business days prior to surgery.

Insured Patients

We will bill your insurance as a courtesy. Please provide us with your correct/current insurance information. Your insurance policy is a contract between you and your insurance company. Confirmation of eligibility and/or pre-authorization does not guarantee payment to the provider. Please be aware that some services provided may not be fully covered. Please check with your insurance company and confirm your coverage and benefits to find out if there are any exclusions in your policy. If you have any questions, please contact your insurance company.

You will be responsible for any outstanding co-pays, coinsurance, and deductibles, and any fees that your insurance does not cover.

I authorize payment(s) of my insurance benefits to Rocky Mountain Surgical Associates, P.C., for all claims. I authorize the release of any medical information necessary to facilitate payment for all claims.

- **Co-pays are due at the time of service.**

I have read and understand the above information. I do not hold Rocky Mountain Surgical Associates, P.C., or any of their physicians or staff responsible for my insurance coverage, pre-authorization, or any insurance decisions.

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Patient Signature Date