Colorado Orthopaedics
Excellence | Experience | Compassion

General Financial Waiver

Patient Name: _____ Date of Service: _____

I understand that if I have failed to comply with the rules of my insurance plan it might prevent my insurance company from paying for the services I am receiving today. The following apply to my visit today:

____ I am unable to present my current insurance card today, and therefore I am unable to provide complete and accurate billing information to the clinic.

____ I refuse to provide my Social Security Number, which may affect the clinic's ability to provide complete and accurate billing information to my insurance carrier.

____ I am unable to present a card with my current PCP (primary care physician) listed OR I have changed my PCP to _____ (provider's name) effective _____ (date), but cannot present a corrected card at this time.

____ I am unable to provide a copy of my prescription/referral that authorizes my visit to see providers at Colorado Orthopaedics, PC but I know that this visit has been authorized by my PCP.

____ I have not checked with my insurance company prior to the visit to verify that I have benefits to cover the services I am to receive today.

I understand that if I am unable to provide complete and current insurance information to my physician's office within 72 hours of this visit that I will be financially responsible for the services I receive today.

I also understand that I will be financially responsible for any service I receive that is not a covered benefit of my insurance plan.

Additionally, if payment is denied by my insurance company as a result of any of the items checked off above, I agree to be financially responsible for the services I receive today.

_____ _____

Signature of Patient or Parent/Guardian Date