ASPEN MEDICAL CARE'S FINANCIAL POLICIES

Welcome to our office. We are pleased that you have chosen Aspen Medical Care, PC to provide your medical care. We want to take a moment of your time to inform you of our policies regarding payment. Payment in full is expected when services are rendered unless other specific arrangements are made in advance. For your convenience, we accept cash, local personal check, MasterCard and Visa, American Express and Discover.

COMMERCIAL/PRIVATE INSURANCE: If we do not have a contract with your insurance, we expect payment at the time of service. We will provide you with the information you'll need to file with your insurance for reimbursement. It is your responsibility to contact your insurance in the event of nonpayment or discounted payments. Many private insurance companies, in an effort to discount physician fees, restrict payment indicating that fees are over their "Usual and Customary" fees for this area. We have ensured that our fees are comparable to that of other offices providing the same quality and level of care. We will not allow insurance companies to set our fees for us.

CONTRACTED INSURANCE: If you have insurance with which we contract, we will submit your insurance claims for you. You will need to provide to us, at the time of service, a valid insurance card, address for submitting claims and a telephone number allowing us to verify coverage. You are responsible for your copay at the time of service and for any amounts not covered by your insurance, including deductibles and coinsurance. Failure to pay your copay at the time of service may result in an additional $15 fee. If you have any special requests or instructions regarding billing for services provided, we must be informed before services are rendered. It is your responsibility to verify with your insurance that you are seeking services from an in-network physician. We will provide information on our participation status based upon the best information available to us at the time, but if coverage is denied for any reason, you are responsible for payment of the entire balance.

WORKERS' COMPENSATION INSURANCE: If your visit involves an accident or work-related injury, we must know the name and address of your employer, the accident date, where it occurred, the nature of the accident, and the telephone number of the adjuster for your case. Workers' Compensation laws require the employee to report injuries to their employer. We cannot bill your regular health insurance for work-related injuries. If this information is not provided, or payment is denied for any reason, you are responsible for payment of the entire balance.

AUTO INSURANCE: If you were involved in an auto accident, we will expect payment at the time of service. We will provide you with the information you'll need to file with your auto insurance for reimbursement.

PRIVATE PAY: If you do not have insurance, we expect you to pay for your visit at the time of service.

MEDICARE: We are a participating provider with Medicare. We will submit your claim to insurance. Medicare will process the payments to us. You are responsible for your deductible and copays at the time of service.

ASPEN MEDICAL CARE'S FINANCIAL POLICIES (cont'd)

NON-PAYMENT: In the event your account is not paid within 30 days of treatment or according to an agreed upon payment plan, interest will be assessed at the rate of 18% per annum on the unpaid balance. If your account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, you will be responsible for all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees and collection agency costs. Insurance benefits are a matter between you and your insurance company. You are ultimately responsible for payment on your account.

RETURNED CHECKS: Returned checks are subject to a $25 service charge.

If you have any questions regarding our payment policies, please ask us before your visit.

ACKNOWLEDGEMENT: I have read and understand the payment policies set forth herein and have been given the opportunity to ask questions about this policy. I understand my responsibility for payment of my account with Aspen Medical Care, PC and have provided to the best of my ability the information requested accurately and completely.

I authorize direct payment to Aspen Medical Care, PC.

_____
Signature

_____
Printed Name

_____
Date