WESTERN NEPHROLOGY

Caring for People with Kidney Disease

AUTHORIZATIONS & CONSENTS

PATIENT FINANCIAL AGREEMENT

Thank you for choosing us as your Nephrology health care provider. We are committed to being a partner in providing conscientious medical care for you. Payment of the bill is considered an important part of that partnership. Thank you for reading our Financial Agreement. Please let us know if you have questions or concerns.

The following is a statement of our Financial Policy, which we require you to read and sign.

It is your responsibility:

- To understand your benefit plan
- To know if a referral is required
- To know if preauthorization is required prior to a procedure, and
- To know what services are covered

Full payment for self-pay patients, co-payments and deductibles are due at the time of service. You may also be asked to pay your coinsurance at the time of service. In the event that you are unable to pay the full amount of your deductible or coinsurance at the time of service, you will be asked to pay a minimum of a $50 deposit towards the total amount due. If your insurance requires a Referral/ Authorization, it is your responsibility to contact your PCP office to request the Referral/ Authorization prior to your appointment. If Western Nephrology does not receive the Referral/ Authorization 72 hours prior to your appointment, you will be asked to self-pay for your visit.

Note: Self-pay patients that are able to pay in full are subject to a 20% discount.

We accept cash, checks, Visa/MasterCard/Discover/AMEX.
Any other arrangements must be made in advance with our Billing Office.

Regarding Insurance:
Your insurance policy is a contract between you and your insurance company. Payment of your bill is ultimately your responsibility. Western Nephrology contracts with and bills most insurance carriers. We also participate with both Medicare and Medicaid of Colorado. If you are insured by a company with which we do not contract, we can supply you with a statement of your charges. You may submit this, along with any additional forms your insurance requires, to your insurance company.

1. I have read and agree to this Financial Agreement.
2. I authorize and consent to the release of medical information necessary to bill and process insurance claims.
3. I authorize payment of medical benefits directly to the physician.
4. If we cannot successfully collect on an outstanding balance, and payment arrangements are not established within 30 days of statement, the cost of collection, including reasonable attorney fees, shall be included as part of the obligation due.

Name of Patient: (Print) ______________________ **DOB** ______________________

Patient Signature: ______________________ **Date** ______________________

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