



## PAYMENT POLICY

### ALL SPORTS MEDICINE OF BOULDER, PC

Thank you for choosing us as your sports medicine provider. We are committed to providing you with high quality and affordable health care. The services insurances will cover and will not cover and what a patient is responsible for financially can be confusing. This payment policy is to help you make some sense of this. Anytime you have questions, please ask.

1. **Insurance.** We participate in several insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up to date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
  
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
  
3. **Non-covered services.** Please be aware that some-and perhaps all-of the services you receive may be noncovered or not considered reasonable or necessary by insurers. You must pay for these services in full at the time of the visit.
  
4. **Proof of Insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of your claim.
  
5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company

pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in **45 days**, the balance will automatically be billed to you.

7. **Nonpayment.** If your account is over **90 days** past due, you will receive a letter stating your account is due in full upon receipt. Partial payments will not be accepted unless otherwise negotiated. Please be aware this if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular mail and certified mail that you have 30 days to find alternative medical care. During that **30 day** period, our physician will only be able to treat you on an emergency basis.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

**I have read and understand the payment policy and agree to abide by its guidelines:**

\_\_\_\_\_  
**Signature of patient or responsible party**

\_\_\_\_\_  
**Date**