

Patient's Name: _____

FINANCIAL ARRANGEMENTS

Please read carefully

As a courtesy to you, we will bill all first and second insurance company claims. Please advise us if you do not want us to file your insurance claims for you.

In order to prevent a misunderstanding about our fees and your medical insurance, we want our patients to know that:

- A. YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. THEREFORE, YOU ARE LIABLE FOR THE BILL, NOT YOUR INSURANCE COMPANY.
- B. In many cases your insurance will pay only part of our fees. Since our relationship is with you, our bill is your personal responsibility.
- C. If you have a balance on your account that is your responsibility, we will send you an invoice. We ask that you pay your personal balance in full or call our billing department to make arrangements.
- D. Payments that are overdue by more than 90 days will be sent to collections.
- E. It is your responsibility to check with your insurance company regarding preferred provider status prior to being seen. If we are not a preferred provider for your insurance company, that will mean more out of pocket expense to you.

Your signature on this form constitutes your agreement to the above policy and all of the conditions herein and authorizes direct payment and assignment of benefits from your insurance company.

Signature: _____ Date: _____

Relationship to patient if other than patient: _____

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