Pt #_____
DMOS_____
INITIALS

DMOS
ORTHOPAEDIC CENTERS

Financial Agreement

DMOS Orthopaedic Centers is committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner for all our patients, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms.

1. I am ultimately responsible for payment of charges for services I receive from this practice including those covered by my insurance. As a convenience, DMOS Orthopaedic Centers will submit claims for reimbursement with my medical insurance plan; however, I am ultimately financially responsible for all charges. I understand that if I do not have active medical coverage I will be required to pay a deposit for urgent care and payment at time of service for future treatment.

2. Co-pays are due at time of service per your insurance plan. Failure to pay could result in rescheduling of my visit until I am able to pay the required amount set by my insurance plan.

3. Pre-collection of deductibles/co-insurance is required on all elective procedures. Deductible amounts are designated by my insurance plan. My deductible is the amount I must pay per my insurance plan before I have benefits for medical care. Once I have met my deductible, I will be responsible for co-insurance percentage. I will contact my insurance company to determine the amount I must pay or contact DMOS billing department for assistance.

4) Durable medical equipment dispensed at my visit may require a cash deposit in the event my insurance plan does not cover the item.

5) It is my responsibility to provide my current address, telephone number, e-mail address, and insurance information at each visit.

6) In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I will receive a monthly statement for any outstanding balance. I am responsible for paying any balance upon receipt to avoid possible collections and/or termination from the practice. If warranted, DMOS Orthopaedic Centers may offer the option of paying my balance via an automated payment plan. I will contact DMOS Orthopaedic Centers billing department at 515-537-2860 to arrange a mutually accepted payment arrangement if necessary.

7) I understand that my signature and payment information will be maintained securely on file digitally for future use by the practice. The applicable payment card or my bank account information will be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information. Card or bank account information will be obtained through a card swipe, manual entry from card, void check, or orally in person or over the phone.

Signature Required on Reverse Side

8) I authorize DMOS Orthopaedic Centers and/or its designated provider to send electronic account statements to my e-mail address on file. I understand that it is my responsibility to maintain a current e-mail address on file and that I will not receive a mailed copy of any electronic statement if I authorize DMOS Orthopaedic Centers to send me e-statements by opting in below.

☐ ___ I opt **IN** to e-statements and agree to receive my statements in electronic format to the
initials
provided e-mail address below.

E-Mail Address for electronic billing statements:_____

☐ ___I have chosen to opt **OUT** of electronic statements and request a monthly paper statement.
initials

9) I authorize DMOS Orthopaedic Centers and/or its designated provider to keep my preferred form of payment securely on file. I understand that it is my responsibility to notify DMOS Orthopaedic Centers if I no longer wish to have this information on file or if my information has changed.

☐ ___ I opt **IN** to keeping my form of payment securely on file and agree to give verbal consent at
initials
check in to process charges through this form of payment.

☐ ___I have chosen to opt **OUT** of keeping my form of payment on file and will provide a form of
initials
payment at check in for each visit.

This authorization will remain in effect until I provide notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice of any changes in my payment or other information.

_____

Patient Name **Patient Date of Birth** **Telephone number**

_____

Signature (required) of Patient or Personal Representative **Date**

_____

Name of Personal Representative (if other than patient) **Relationship to Patient**