

**Alpine Orthopedics**  
**536 Cottonwood, Ste 100**  
**Bozeman, MT 59718**  
**406-586-8029**

**Financial Policy**

We will bill your primary insurance company as a courtesy to you. Please note that we do not bill your secondary insurance for you. **It is your responsibility to verify coverage and/or pre-authorization of any services, supplies or procedures prior to services by our staff.**

**Statement of Financial Responsibility**

I understand that I am responsible for the payment of this account regardless of insurance coverage or other third party involvement. I hereby assume and guarantee prompt payment of all expenses incurred.

**Notice of “Non-Covered” Services**

I am aware that my insurance carrier may consider some services and/or supplies “non-covered”, therefore I will become fully responsible for the payment of these charges.

**Assistant Surgeon Charges**

I am aware that should I have a surgical procedure, my doctor may require the assistance of a qualified assistant surgeon, P.A or surgical RN. The assistant fee is 20% of the surgeon’s fee per procedure. I am aware that I am responsible for these charges if not covered by my insurance.

**Insurance Assignment and Release of Information**

I hereby assign benefits to be paid directly to Alpine Orthopedics and Sports Medicine. I hereby authorize Alpine Orthopedics and Sports Medicine to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. In the event that my account becomes past due, I understand that I agree to pay all collection costs, attorney costs and court costs necessary to collect payment. I have read all of the above and understand/agree to all the provisions therein regarding my financial responsibility and release of information.

PRINT Patient’s Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient or Legal Guardian’s Signature: \_\_\_\_\_

If Legal Guardian, Relationship to Patient: \_\_\_\_\_

