Financial Responsibilities Agreement

Alliance Prosthetics & Orthotics (Alliance P&O) is committed to providing high-quality care and ensuring transparency regarding financial responsibilities. Please review and acknowledge by **initialing in the blanks** for the following:

1. Insurance Coverage & Financial Responsibility
    - I understand that there is no guarantee of payment from my insurance company, and I am responsible for verifying my benefits, deductible, and coinsurance before receiving services.

    ____ Alliance P&O may provide an estimate based on information from my insurance provider, but this is not a guarantee of payment.
2. Billing & Payment Process
    - My device will be billed to my insurance after delivery using the billing codes determined by the practitioner.

    ____ Insurance cannot be billed prior to delivery; therefore, if you have a change of insurance after ordering you could be responsible for the entire amount.

    ____ If the final insurance payment differs from the estimate, I may owe an additional balance or be issued a refund.
3. Payment Responsibility

    ____ I am responsible for any deductible that applies to my insurance policy, and I am responsible for any copayment or coinsurance as determined by my insurance policy.

    ____ Estimate provided is a "best guess" and may not reflect the final amount owed.

    ____ If paying by check, should the check fail to process we will charge a $25 processing fee each time a check fails to process.
4. Device Policy

    ____ Yes ____ No: I have previously had a device on that leg/foot/knee before OR I have previously had a back brace before.

    ____ Custom devices are non-refundable unless there is a manufacturer defect.

    ____ If I am unsatisfied with my device, adjustments can be made to ensure proper fit and function.

Disclosures

By signing below, I acknowledge that I have read and understand my financial responsibilities as outlined above. I hereby authorize Alliance Prosthetics and Orthotics to submit claims on my behalf to the insurance company I have provided to them. I hereby authorize all payments, rights and claims for reimbursement of claims, costs and expenses allowable under my insurance plan(s) directly to Alliance Prosthetics and Orthotics for services rendered. I understand that I will receive a statement for any balance due by me and I agree to make full payment upon receipt of the statement after insurance has met its obligation.

Patient Signature: _____

Date: _____

Authorized Representative: _____

Relationship to Patient: _____

Patients with Medicare or Medicare Advantage Plans ONLY

By signing below, you are confirming that we have provided a copy of the Medicare Supplier Standards for your review today.

The products and/or services provided to you by Alliance Prosthetics and Orthotics are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at http://www.ecfr.gov. Upon request we will furnish you a written copy of the standards for your records.

Patient Signature: _____

Date: _____

Authorized Representative: _____

Relationship to Patient: _____