DMOS ORTHOPAEDIC CENTERS
ANKENY • DES MOINES • WEST DES MOINES

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 and non-covered by my insurance. As a convenience, DMOS Orthopaedic Centers will submit claims for reimbursement to my medical insurance plan; however, I am ultimately financially responsible for all charges.
2. It is my responsibility to provide accurate and current address, telephone number, e-mail address, and insurance information at each visit.
3. I understand that if I cannot show proof of active medical coverage I will be required to pay a deposit.
4. 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.
5. Pre-collection of deductibles and/or co-insurance is required on all elective surgical 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 a co-insurance percentage.
6. Durable medical equipment (DME) dispensed at my visit may require a cash deposit in the event my insurance plan does not cover a particular DME item prescribed by a DMOS provider.
7. 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.
8. 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.
9. I authorize DMOS Orthopaedic Centers and/or its designated vendor 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.
10. I understand by entering or assigning a guarantor to my account, I am authorizing DMOS to send account information, including Personal Health Information on the billing statement, to the noted guarantor and release my HIPAA rights to share information related to billing.
11. I understand that by assigning a guarantor, I may still be accountable to my portion of patient payment of charges for services I receive from this practice.

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: _____ Date of Birth:_____

Signature of Patient/Personal Representative: _____Date: _____

Name of Personal Representative (if other than patient):_____

Relationship to Patient:_____