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.

    ____ 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.

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 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: _____