Boulder Breast Center
AT ALPINE SURGICAL
Comprehensive Breast Care

Boulder Breast Center
4743 Arapahoe Avenue Suite 102
Boulder CO 80303
www.boulderbreastcenter.com
Phone 303.449.3642 Fax 303.440.7298

ALPINE SURGICAL FINANCIAL POLICY – PLEASE SIGN EACH PAGE

Thank you for choosing Alpine Surgical. We appreciate the trust that you have placed in our practice by asking us to evaluate and treat you.

Insurance Payments

Insurance is a contract between you and your insurance carrier. We will bill your primary and secondary, if applicable, insurance carrier as a courtesy to you. If you have a co-payment and/or deductible, you are required to pay those amounts, as they are your responsibility. All co-payments are due at the time of your visit. There is no exception to this policy. Your insurance carrier makes the final determination of your eligibility and benefits. You agree to pay any and all portions of the charges.

Contracted Insurance: If we have an established contract with your insurance company, we will follow the terms, conditions and requirements of said contract. Your insurance company makes the final determination of your eligibility and benefits. You agree to pay any and all portions of the charges that are not covered by your insurance.

Non-Contracted Insurance: If Alpine Surgical does not have a contract with your health insurance carrier, you will be responsible for all charges not covered under your health insurance plan.

Medicare: We accept Medicare assignment. Medicare patients are responsible for their annual deductible and co-insurance. If you have a supplemental insurance, we will bill it directly. If you have a Medicare Advantage plan, you are required to pay your co-payment at the time of service.

Patients with an HMO: It is your responsibility to know and understand your HMO Medical Plan. If your HMO requires a referral and/or preauthorization for your initial consultation, you are responsible for obtaining it and submitting it to us prior to your visit. You will not be billed as long as we have the necessary referrals and/or pre-authorizations. It is your responsibility to verify with your insurance company that we are in your plan.

Patients with a PPO: You are responsible for your co-payment, deductible, and your co-insurance. All co-payments are due at the time of your visit. It is your responsibility to verify with your insurance company that we are in your plan.

Self-Pay Patients: You will be required to pay 100% of all charges at the time of your visit.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full. We will also verify that your employer assumes responsibility for all charges incurred. If we cannot verify responsibility or we are unable to obtain information on your employer's worker's compensation insurance, you will be billed.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require written verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance company. In the absence of insurance, other financial arrangements can be arranged. Payment of the bill remains the patient's responsibility whether a lawsuit has been filed or not. Payment in full is due with 30 days of receipt of our invoice.

For All Insurance Payment Options -- Alpine Surgical will file your charges with your primary and secondary insurance carrier. You must present your insurance cards at each visit. If you change insurance companies, you are responsible for informing us of the change, and present new insurance cards at the time of your visit. If this information is not provided, and we submit claims to the carrier that we have on record, and the claims are denied, you will be responsible for payment for all services provided.

Once Alpine Surgical has received payment from your insurance company a statement with the remaining charges for both covered and non-covered services will be sent to you. Payment is expected in full within 30 days of receipt of this invoice. Unless Alpine Surgical approves other arrangements, if payment is not received within 30 days your account is considered past due and is subject to collections.

Prior to elective surgery, Alpine Surgical will contact your insurer to obtain pre-certification and verify benefits. This process does not guarantee payment. Alpine Surgical will also ESTIMATE your out of pocket expenses based on your coverage and benefits and you will be required to pay this amount PRIOR to the procedure.

Signature: _____ Date: _____

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Surgical Assists: Many times a surgeon requires an assistant during surgery. If your surgery requires a planned or unplanned assistant to be present, you will receive a separate bill from his or her office.

Surgery Charges: The charges from Alpine Surgical are usually 20-25% of your total charges. The hospital fees, anesthesiologist, pathologist, surgical assistant, and lab often make up the rest. Alpine Surgical will bill you for the services rendered by Dr. Fox and Dr. Gawart, and you will receive a separate bill from the other offices for their services rendered.

Payment Plans: Alpine Surgical is willing to work with you to assist you in paying off your outstanding balance. We have an established payment plan program and payments for your outstanding charges can be divided into, no more than, 3 (three) monthly payments. A valid credit card must be presented at the time the plan is established. Your signature to our payment plan forms is required. Your signature acts as your authorization for us to charge your credit card on a monthly basis. This authorization remains in effect until the outstanding balance is zero. Your credit card statement will show the monthly payment and will serve as your receipt.

Missed Appointment Fee: Patients who fail to show up for a scheduled appointment, or cancel with less than 24 hours notice will be charged a $100 No Show Fee for each Provider they were scheduled to see. This fee must be paid before a new appointment is scheduled. This fee is your responsibility and is not covered by insurance, and if not paid is subject to collections. Patients with three missed appointments will be asked to transfer their records to another physician. This fee is subject to change without notice.
Initials _____

Cancellations of Surgical and Vascular Procedures: If you need to re-schedule a surgical or a vascular procedure (EVLT/MICRO) you must provide 72 hours (3 days) notice. Patients who do not cancel their appointment within this time frame and do not show up for the procedure will be charged a $300 cancellation fee. This fee must be paid before a new appointment is scheduled. This fee is your responsibility and is not covered by insurance, and if not paid is subject to collections. This fee is subject to change without notice.
Initials _____

Returned Check Fee: There is a fee (currently $30) for any checks returned to us by our bank. This fee can change if our bank increases its fee on returned checks. You will be responsible for payment of this fee and for future visits cash or a valid credit card must be used for payment.

Past Due Accounts: If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer your accounts to a collection agency, you agree to pay all of the collection costs that are incurred. If we refer collection of the balance to a lawyer, you agree to pay all lawyers' fees that we incur plus all Court costs.

Waiver of Confidentiality: You understand if your account is submitted to an attorney or collection agency, if we have to litigate in Court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Medical Records: Your request must be in writing. If Alpine Surgical is releasing records to an entity not covered under HIPAA, a fee will be charged based on the number of pages in your record. You will be informed of the total charges, and the fee must be paid before any and all records are released. You authorize us to include all relevant information, including your payment history.

Effective Date: By signing this agreement, you are agreeing to pay for all services that you, and/or your dependent, receive. You are ultimately responsible for payment for all services rendered.

Patient's Name: _____

Responsible Party: _____
(If not the Patient)

Signature: _____ Date: _____

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ALPINE SURGICAL FINANCIAL POLICY – PAYMENT PLAN

Alpine Surgical is willing to work with you to assist you in paying off your outstanding balance. We have an established payment plan program. Payments for your outstanding balance and/or charges can be divided into, no more than, three (3) monthly payments. **A valid credit card must be presented at the time the plan is established.**

First payment is due at the time the payment plan is established. Your agreement to this payment plan will be recorded in Alpine Surgical's financial system and will act as your authorization for us to charge your credit card on a monthly basis. This authorization remains in effect until the outstanding balance is zero. Your credit card statement will show the monthly payment and will serve as your receipt.

Patient hereby acknowledges and agrees that any account that becomes delinquent will be subject to a collections agency. The Patient agrees to pay all court costs and reasonable attorney fees for collection of all past due amount owed plus interest thereon at 18 (eighteen) percent per annum on all such amounts outstanding.

Patient agrees they have read and understand this payment plan policy. By signing this, you are NOT setting up a payment plan. If a payment plan is required, please inform the front desk so that one can be arranged.

Patient Name (Print):_____

Patient/Guardian Signature:_____ **Date:**_____

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WHEN REGISTERING, PLEASE PRESENT YOUR PROOF OF INSURANCE, OR PAYMENT IN FULL IS EXPECTED AT THE TIME OF SERVICE

	Primary Insurance	Secondary Insurance	Other
Name of Insurance Co.			
Policyholder			
Policyholder's SS#			
Policyholder's DOB			
Policyholder's Place of Employment			
Relationship to Patient			
Policy/ID Number			
Group/Account Number			
PPO? HMO? Other?			
Co-pay Amount			

I hereby instruct and direct my Insurance Company to pay by check made out and mailed to:
Alpine Surgical, LLC, P.O. Box 18674, Belfast, ME 04915-4081

A photocopy of this agreement shall be considered effective as the original.

I also authorize the release of any information pertinent to my claim and all future claims to my insurance company or adjuster involved in this case and certifies that this insurance information is current and valid.
I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I agree to pay in full for any services rendered within 30 days of receiving a bill. **All co-pays are due at the time of service**. I understand that failure to supply the office with all of my insurance and/or referral information could result in denial of my insurance claim. If patient does not have insurance coverage, or if the services rendered are not covered by insurance, payment is expected at the time of service.

☐ **Check Here If No Health Insurance**

Patient Signature: _____ **Date:** _____
(Parent, if patient is a minor)

Workers Compensation Claim:

Date of Injury: _____ Claim Number: _____
Employer: _____
Person and Phone Number to contact at employer for insurance information: _____
Insurance Company Name & Phone Number: _____
Adjuster's Name and Phone Number: _____
Please describe what happened: _____

Personal Injury Claim:

Date of Injury: _____ Claim Number: _____
Insurance Company: _____
Adjuster's Name: _____ Phone Number: _____
Attorney's Name: _____ Attorneys Telephone Number: _____

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PERSONAL INFORMATION: **Today's Date:**_____

NAME: Last, First, MI: _____ ☐ Male ☐ Female ☐ Other

Mailing/Billing Address: _____ City: _____ State: _____ Zip: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Home Phone Number: _____ Cell Phone Number: _____

Work Phone Number: _____ Email Address: _____

The office may leave detailed messages on my: ☐ Home Phone ☐ Cell Phone ☐ Work Phone

Date of Birth:___/___/_____ Age:_____ Social Security Number: _____/____/_____

Height:_____ Weight:_____ Blood Pressure (if Known): _____

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Marital Status: **O** Single **O** Significant Other **O** Married **O** Legally Separated **O** Divorced **O** Widowed

Spouse's/Other's Name:_____Work/Cell Phone Number:_____

Primary Care Physician:_____Phone Number:_____

Whom may we thank for referring you to us:_____ ☐ Friend ☐ Doctor ☐ Other

WHAT PHARMACY DO YOU CURRENTLY USE? _____
PHARMACY ADDRESS: _____

PHARMACY PHONE NUMBER: (_____) _____

EMERGENCY CONTACT:

Name:_____ Home Phone:_____

Address:_____ Work Phone:_____

City:_____ State:_____ Zip:_____ Cell Phone: _____

Relationship:_____

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This is a confidential record of your medical history and will be kept in this office.
Information contained herein will not be released to any person except when you have authorized us to do so.

REASONS FOR THE OFFICE VISIT TODAY (Please list primary symptoms/concerns):

1._____Right/Left

2._____Right/Left

PERSONAL MEDICAL HISTORY (PLEASE COMPLETELY FILL IN BUBBLES THAT APPLY TO YOUR HISTORY)

Diabetes	O Yes	GERD	O Yes
HyperThyroidism	O Yes	Colitis	O Yes
HypoThyroidism	O Yes	Diverticular Disease	O Yes
HyperParathyroidism	O Yes	Kidney Stones	O Yes
Elevated Cholesterol	O Yes	Kidney Failure	O Yes
Heart Attack	O Yes	Seizures	O Yes
Heart Arrhythmia	O Yes	Asthma	O Yes
Heart Failure	O Yes	COPD/Emphysema	O Yes
Stroke/TIA	O Yes	Sleep Apnea	O Yes
Blood Clot	O Yes	HIV/AIDS	O Yes
Pulmonary Embolism	O Yes	Cancer	O Yes
Anemia	O Yes	Type of Cancer_____	
High Blood Pressure	O Yes		
Peptic Ulcer Disease	O Yes	**Check here if NONE of these apply** ☐	

Other Medical History:_____

SURGICAL HISTORY: (Circle all that apply and include proximate dates of Surgeries) **Check here if no surgical history** ☐

Hernia: Inguinal/Umbilical/Other_____
Dates:_____

Rectum: Hemorrhoids/Fistula/Fissure/Other_____
Dates:_____

Abdomen: Gallbladder/Appendix/Stomach/Intestine/Colon
Other_____
Dates:_____

Breast: Lumpectomy/Mastectomy/Reconstruction/Biopsy
Dates:_____

Head/Neck: Thyroid/Parathyroid/Tonsils/Other_____
Dates:_____

Chest: Heart Bypass/Heart Valve/Heart Catheterization
Lungs /Other_____
Dates:_____

Kidney: Stone/Other_____
Dates:_____

OB /GYN: Hysterectomy/Tubes or Ovaries/C-Section
Dates:_____

Orthopedic: Shoulder/Knee/Hip/Other_____
Dates:_____

Other Surgeries and Dates:_____

_____

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MEDICATIONS: List any medications you are currently taking (including herbals and supplements).

Check here if NONE ☐

Medication	Frequency	Medication	Frequency

ALLERGIES: Please specify if you are allergic to any medicines or medical supplies (including iodine, tape, latex, and shellfish). **Check here if NONE** ☐

ALLERGY and REACTION (example: Latex-Rash)	ALLERGY and REACTION

SOCIAL HISTORY:

Alcohol **O** Yes **O** No How Often_____

Smoking **O** Yes **O** No How Many Per Day/Week_____

Recreational drugs **O** Yes **O** No Explain What and How Often_____

FAMILY MEDICAL HISTORY: Please indicate if any blood related family members have ever had any of the following

Indicate either Maternal or Paternal side AND Family Member Relationship (i.e. Maternal Grandmother, Paternal Aunt, etc.)

Bleeding problem _____

Heart attack / Stroke_____

Problems with anesthesia_____

Epilepsy/Seizures _____

Diabetes_____

Asthma_____

High blood pressure _____

Cancer (List Type and Family Member)_____

IMAGING: Have you had any imaging for this problem (including MRI, X-Ray, Mammogram, Ultrasound).

Check here if NONE ☐

Type	Date	Location (Facility)

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Personal Review of Systems: Have you had any of these recently?

Please Completely Darken ALL Bubbles. Answer ALL Questions.

Constitutional			Gastroenterology		
Weight Change	O Yes	O No	Difficulty Swallowing	O Yes	O No
Loss of Appetite	O Yes	O No	Heartburn	O Yes	O No
Fever	O Yes	O No	Abdominal Pain/Cramping	O Yes	O No
Weakness	O Yes	O No	Nausea/Vomiting	O Yes	O No
Fatigue	O Yes	O No	Diarrhea	O Yes	O No
Night Sweats	O Yes	O No	Blood in Stool	O Yes	O No
Dermatology			**Genitourinary**		
Rash/Hives	O Yes	O No	Changes in Urination	O Yes	O No
Moles/Lumps/Skin Cancer	O Yes	O No	Blood in Urine	O Yes	O No
			Groin Bulges	O Yes	O No
Endocrinology			Testicular Pain	O Yes	O No
Excessive Sweating	O Yes	O No			
Heat/Cold Intolerance	O Yes	O No	**Psychology**		
Anxiety	O Yes	O No	Tension/Stress	O Yes	O No
Jitteriness	O Yes	O No	Sleep Disturbances	O Yes	O No
Hair Change	O Yes	O No	Suicidal Ideation	O Yes	O No
Low Libido	O Yes	O No	Eating Disorder	O Yes	O No
Memory Loss	O Yes	O No	Depression	O Yes	O No
Neurology			**Musculoskeletal**		
Headache	O Yes	O No	Joint Pain	O Yes	O No
Tingling/Numbness	O Yes	O No	Joint Swelling	O Yes	O No
Seizures	O Yes	O No			
Dizziness	O Yes	O No	**ENT/Respiratory**		
			Cough/Cold	O Yes	O No
Ophthalmology			Change in Voice	O Yes	O No
Diminished Vision	O Yes	O No	**Cardiovascular**		
Blurring of Vision	O Yes	O No	Chest Pain	O Yes	O No
			Palpitations/Murmurs	O Yes	O No
Hematology			Leg Cramping	O Yes	O No
Easy Bleeding	O Yes	O No	Leg Pain at Rest	O Yes	O No
Bruising	O Yes	O No	Varicose Veins	O Yes	O No
Swollen Glands	O Yes	O No			

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Today's Date: _____

PATIENTS FULL NAME (please print):_____ Date of Birth:_____

GUARANTOR INFORMATION : Person who is responsible for payment.

Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Home Phone:_____
Date of Birth:_____

Employer Name:_____
Employer Address:_____
City:_____ State:_____ Zip:_____
Employer Phone:_____
Relationship to Patient:_____

Please complete the section below if you are over 18 and wish to allow a friend, spouse, parent, or other family member to discuss medical and/or billing information with our office.

Authorization to Discuss Medical and Billing Information

I,_____, hereby authorize Dr. Richard Fox/Dr. Akin Beckley and the staff of Alpine Surgical to discuss my medical and billing information with the following listed persons.

First and Last name of authorized person:	Relationship: (i.e.: mother, son, spouse, friend)
1:_____	1:_____
2:_____	2:_____
3:_____	3:_____
4:_____	4:_____

Patient Signature:_____Date:_____

HIPAA PRIVACY PRACTICE NOTICE

I acknowledge reviewing the HIPPA Privacy Practice Notice and understand the policy of this office. A copy has been offered to me for my records.

Patient/Guardian Signature:_____**Date:**_____