MILLSAP VALLEY
ORTHOPAEDICS
& SPORTS MEDICINE

Financial Agreement

Donal "Buck" Rose, MD
924 Foster Lane
Weatherford, TX 76086
(817) 596-8200 Millsapvalley.com

***Payment**: Payment is expected in full for each appointment as services are rendered. Payment options are:
*****Cash *****Check *****Credit Card (Master Card or Visa)

***Medical Insurance**: Insurance is a contract between you and your insurance company. There is no direct relationship between our office and your insurance company. Your insurance benefits are determined by the type and design of plan chosen by you and/or your employer and we are not a party to this contract. We have no control over the terms of your contract, the method of reimbursement, or the determination of your benefits. Some and perhaps all of the services can be defined by your insurance company as "not covered" "denied". We will file your primary and secondary medical insurance claims as a courtesy to you. We do not guarantee payment and are not responsible for providing you with the plan limitations, exclusions, and provisions determined by your insurance company. You agree to pay a portion of the charges not covered by your insurance. If your insurance company requires a referral you are responsible for obtaining it we will file a predetermination for recommended treatment when it is requested by you.

***Missed Appointment Fee**: Our office requests 24 hours notification if you are unable to keep your scheduled appointment. If less than 24 hour notice is given, a $25.00 fee will be charged to your account. Patients with three missed appointments may be asked to transfer their records to another doctor.

***Returned Checks**: There is a fee ($30.00) for any checks returned by the bank.

***Monthly Statement**: If you have a balance on your account, we will send you a monthly statement. It will show the previous balance, and any new changes to the account, if any payments or credits applied to your account during the month. Professional fees are the responsibility of the patient, parent, or guardian authorizing treatment; we cannot send statements to other persons.

***Past Due Accounts**: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to an attorney and/or collection agency, you agree to pay all of the collections cost which are incurred.

***Divorce**: In case of divorce or separation, the responsible party prior to the divorce or separation remains responsible for the account. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

***Effective Date**: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

***This is an agreement between Dr. Donal "Buck" Rose, MD, an orthopedic surgeon, and the patient/debtor named on this form.*
***In this agreement the words "you" and "yours" mean the patient/debtor. The word "account" means the account that has been established in your name for you or your child to which charges are made and payments are credited. The word "we", "us", and "our" refer to Dr. Donal "Buck" Rose, MD.*
***By executing this agreement, you are agreeing to pay for all services that are received.*

_____ _____ _____
Patient's name printed signature date

_____ _____ _____
(if patient is under 18 years old) Patent / Legal Guardian / Responsible party
_____Office Witness _____ date