

CHAMPLAIN VALLEY ORTHOPEDICS, PC  
1436 EXCHANGE STREET  
MIDDLEBURY, VT 05753  
(802) 388-3194

### OFFICE PAYMENT POLICY

We are committed to providing you with the best orthopedic care possible. Your treatment is between you and Champlain Valley Orthopedics. Your insurance is between you, your employer, and your insurance company.

1. We will submit bills to your insurance or provide you with a receipt for you to file your own claim.
2. Under some insurance plans, you may be responsible for charges not covered by your insurance.
3. If we have not received payment from your insurance company and you believe you are covered, it is your responsibility to contact your insurance company.
4. **If you are claiming Worker's Compensation, you must provide us with the Worker's Compensation insurance carrier of your employer. If this information is not provided, you will be responsible for all charges.**
5. Accounts 90 days overdue will be considered delinquent and referred to a collection agency. You agree to pay all costs of collection fees including payments of reasonable attorney's fees incurred by Champlain Valley Orthopedics, PC or their assignees.
6. **If you are not covered by insurance, payment is expected at the time services are rendered. We accept cash, checks, Mastercard, Visa and Care Credit.**
7. If you have a co pay, payment is expected at the time of service. If we have to bill you for your co pay, a \$5.00 fee will be added.
8. We DO NOT accept responsibility for billing claims in litigation. Payment is expected directly from the patient at the time of service.
9. **A 24 hour notice is required if you are unable to keep your scheduled appointments, otherwise you will be charged a \$50.00 fee.**

All charges are **your** responsibility from the date service is rendered. If you are experiencing financial difficulties we ask that you contact us promptly. A partial payment is always better than no payment.

Signature authorizes payment of insurance benefits to Champlain Valley Orthopedics and authorizes release of medical information requested by your insurance company.

**Regardless of any insurance coverage I may have, I accept responsibility for payment of services rendered.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### PERMISSION STATEMENT

I hereby give permission to Champlain Valley Orthopedics, PC to examine and treat my son/daughter, including obtaining diagnostic tests and x-rays.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date