THE HAND CENTER
COLORADO

It Is Your Responsibility to Notify Us If Your Insurance Changes.

Authorization of Treatment: I hereby authorize The Hand Center, P.C. to provide reasonable and proper care.

Signature of patient or responsible party: _____

Authorization to Pay: I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to the Hand Center, P.C. for surgical and medical services rendered. I understand that it my responsibility, not the physician's, to know the specifics of my particular insurance coverage. I understand any charges incurred not covered by my insurance are my responsibility, including co-pays, deductibles and co-insurance. I further understand that for any non-accepted workers' comp claims any charges not covered are my responsibility. I understand that all charges not covered by a third party are my responsibility. I agree to pay all collection costs and attorney fees.

Date: _____

Signature of patient or responsible party: _____

I agree to charges made against the following credit card for any uncollected funds that are over 30 days late that are not covered by my insurance company.

Credit Card (circle one): Mastercard Visa American Express other: _____

Credit Card number: _____

Expiration: _____

Billing address: Same as home or _____

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Suite 223
Broomfield 80020

4745 Arapahoe Boulevard
Suite 140
Boulder 80303

1606 Prairie Center Parkway
Suite 250
Brighton 80601

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