Financial Agreement

Please sign and return prior to surgery.

WASHINGTON INSTITUTE ORTHOPEDIC CENTER

I have read and understand the above financial policy. I understand that I am responsible for contacting my insurance company to obtain pre-certification on any physical therapy visits, CT scans, MRI's or anything else that my doctor requires for the surgery. I also understand that I am financially responsible for any portion of bills related to my surgery that are not covered by my insurance company and that no discounts or reduction of the amount billed will be negotiated after services are rendered.

Surgery Date: _____

Patient Name (print): _____

Patient Signature or Other Financially Responsible Person: _____

Relationship of Legally Responsible Person to Patient: _____

Date: _____

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