Patient Name:_____Date of Birth:_____

ROCKY MOUNTAIN
URGENT CARE & FAMILY MEDICINE

Thank you for choosing us as your primary or urgent care provider! We are committed to providing you with premium quality, affordable health care.

INSURANCE We participate in most insurance plans, including Medicaid and Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. For patients in urgent care, we may not be able to submit a secondary claim to your secondary insurance provider, however we will provide instructions at your request on how to handle this so that you are reimbursed appropriately, should you receive a bill.

CO-PAYS & DEDUCTIBLES All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. If you have an insurance plan with a high deductible or a plan with a co-insurance, please be advised that you may be responsible for paying your insurance provider's portion (roughly half of what we bill them) until that deductible has been met. Due to the many varying complexities of each insurance plan, we are only able to provide you with an ***ESTIMATE*** of what you may owe. If you haven't met your deductible, we require a payment of $75.00 per visit which will be applied to that visit. If we find we have over or under charged you after your insurance company has processed the claim, we will refund you. If in the event that you have a high deductible plan you may still have a remaining patient balance due for each visit.

NON-COVERED SERVICES Please be aware that some of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

PROOF OF INSURANCE All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and a current, valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

UNVERIFIED INSURANCE COVERAGE Our office staff will attempt to verify each patient's insurance coverage at the time of service. If we cannot verify your coverage at the time of service, you will be required to pay $150.00 prior to your appointment. Once your insurance payment has been received, any remaining credits will be credited back to the card on file.

CLAIMS SUBMISSION We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

COVERAGE CHANGES If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

NONPAYMENT If your account is over 90 days past due, your account will be placed in internal collections. Payment plans are available and MUST be set up through the billing office. Please be aware that if a balance remains unpaid, we may refer your account to an outside collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

MISSED APPOINTMENTS Our policy is to charge for missed appointments not canceled 24 hours prior to scheduled time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

RETURNED CHECKS Should your check be returned for any reason, you will be assessed a $50 returned check charge. All future balances will be payable with credit or debit card ONLY.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy, and please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

_____ _____

Signature of patient or responsible party **Date**