

Patient Name: _____

Date: _____

It is the office policy to inform you of our patient payment procedure. Please review the section below that is applicable to you.

1. Patient With Insurance

You will be asked to present your insurance card at each visit. If you do not have all the necessary information with you, you will be billed directly until you are able to provide all of the required information. You are responsible for deductibles, copays, noncovered services, coinsurance and items considered "not medically necessary" by your insurance company. Please pay co-payments and coinsurance amounts as services are rendered. The remaining balance should be taken care of within one (1) month of notice from insurance company. If you or your insurance carrier makes payment exceeding your balance, reimbursement will be remitted. If payment cannot be made at each visit, notify the front desk staff to make other arrangements.

2. Parent/Child

The adult accompanying the child is responsible for payment at the time of service including co-payment. The parent/guardian with whom the child resides is the person who will be billed for services rendered. We will not be involved in mediating financial arrangements between parents/guardians. We will bill insurance as stated above.

3. Medicare

Our office will submit your Medicare charges to WPS Medicare and your secondary insurance. You are responsible for deductibles, copays, and any noncovered services.

4. Worker's Compensation Patient

As a Worker's Compensation patient you may be covered by insurance if your injury is reported at work and verified with your employer. Be sure to inform the office personnel that your injury resulted during employment. Patient is ultimately responsible for the balance.

5. Personal Injury (Accident)

If you are a personal-injury patient our office will bill the appropriate insurance company. If we are unable to obtain payment, the charges for the services rendered will be your responsibility. Please give all information needed for billing.

ASSIGNMENT

_____ I request that payment of authorized Medicare benefits be made either to me or on my behalf to Mountainview Family Practice for any service furnished me by that provider.

_____ The signature below authorizes payment of mandated Medicare benefits to Mountainview Family Practice.

Medigap _____ Policy Number _____ Group Number _____

_____ I assign the benefits from my insurance carrier(s) to this clinic for the medical/surgical benefits I am entitled to.

I have read and agree to the Financial Policy, and Assignment paragraphs stated above that apply to me.

X _____
Patient or Responsibility Signature Date

_____ Person signing on behalf of patient (print name) Reason patient cannot sign

_____ Relationship to Patient Address Phone