

### **Financial Policy**

You are valued as a patient within our practice and we feel it is important to keep you informed that there are ongoing changes in the healthcare industry. These changes may affect you in the services that you may receive that are covered by your insurance carrier, or in services that you receive that are determined to be due and payable directly by you.

### **Cancellation Policy**

Please be aware that our office **may charge a fee of \$25.00** if 24 hours' notice is not given for cancellations. A patient may be charged \$25.00 for no show appointments. The doctor has set aside a significant amount of time for your appointment. In order to be able to accommodate the needs of all of our patients, we need adequate notice if you cannot keep your scheduled appointment. A patient with chronic no shows may be dismissed from the practice.

### **Insurance Identification**

We will make every effort to properly identify your coverage and to submit claims on your behalf to your insurance carrier to obtain their prompt payment. The terms of your insurance coverage may limit the specialists you see and what hospitals and laboratories you need to use. **Please assist us in helping you to meet the terms of your coverage by presenting your current insurance card at the time of each and every visit.**

### **Non-Covered Services**

The terms of your insurance coverage have specific guidelines that indicate services that are covered and services that are not covered under your health insurance policy. It is possible that your insurance may not cover services that our physicians feel to be necessary in maintaining your health. We ask that you become familiar with your insurance policy and identify for your own knowledge services that are not a benefit of your policy.

### **Preventative Health Services**

Preventative health services, such as annual exams, well woman checkups, complete physical exams, etc., vary in coverage from carrier to carrier. There are many carriers who do not provide benefits for routine care and preventative medical services. We feel strongly that screening for a potential health problem is an essential component of maintaining your health and do request that you schedule and receive these important services when recommended by your physician. It is your responsibility to understand the terms of your policy with regards to preventative and routine services. Management of past or current health problems or treatment of new problems discovered during your physical may result in an office visit copay or deductible. We will bill you after the insurance processes your claim.

### **Telehealth**

Colorado Physician Partners is pleased to provide an option for patients to see their provider virtually through a secure video platform. Virtual visits (telehealth) use telecommunications technology to provide real-time health care to patients. Virtual appointments must be approved by your PCP. Telehealth visits may not be a benefit of your insurance policy and you may be liable for the service performed. Patients will be liable for charges which may include co-pays, co-insurance and/or deductibles for this service.

### **Non-Physician Services**

There may be times within our practice when you receive services such as injections, blood pressure checks, drawing of blood for evaluation of a condition and not see a physician directly on the same day. These nurse services are

processed as a minimal office visit within our practice as outlined under the American Medical Association's current procedural guidelines for correct coding procedures. Some insurance carriers do not require patients to make co-payments for minimal office visits. However, there are some that do require a co-payment from you for these services. If your insurance carrier is one that requires co-payment for minimal office visits, you may be billed for this at a later date.

**Compliance with Guidelines and Requirements of Health Insurance Carriers**

It is our office goal to accurately and clearly identify to your health insurance carrier the services that you receive and the reason you received these services. Please do not ask our physicians or our staff to alter our reporting of the services you receive or are about to receive. **Any alteration in our coding system would be considered fraudulent and we simply are not able to alter our coding in any way.**

**Out of Pocket Expenses**

All out of pocket expenses, which are based upon the terms of your coverage, are due and payable at the time services are rendered. **Co-Payments, under the terms of your coverage, must be paid at the time of service. Patients that have not met deductible will be required to pay minimum of \$50 at time of service.** We do require that patients without health insurance coverage make full payment or payment arrangements at the time of service. Our billing office will submit to you a statement of your balance due based on the information we receive from your insurance carrier. If you disagree with their determination, you will need to contact the insurance directly.

**Patient Paper Work**

The office will charge a flat fee of \$30.00 to complete patient paper work. The fee must be paid when you pick up your documents.

**Collection Agency**

I consent to the Agency of Credit Control, Inc., and its assignees to communicate with me by telephone, email, fax, or other means, should my account default and be sent to outside collections.

Thank you for your support in complying with our financial policy.

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**Insurance claims are filed as a courtesy, but it is my responsibility to see that claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance. I fully understand that I am responsible for all costs of collection including attorney fees, collection fees, interest assessed on unpaid balances and court costs.**

**My signature below indicates that I have been provided the opportunity to read the office financial policy and ask questions, and that I agree to comply with this policy in providing payment for services rendered.**

\_\_\_\_\_  
Clearly Print Name

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

<b>For Office Use</b>	
<input type="checkbox"/> Note with instructions added to PM	
<input type="checkbox"/> Document scanned into the EHR	
Employee Signature: _____	Date: _____