15 South 1000 East, Suite 225
Payson, Utah 84651

Patient Financial Policy

Patient Name: _____ **DOB:** _____

Thank you for choosing **Rock Creek Neurosurgery**! We are committed to the success of your medical treatment and care. Please understand that a mutual financial understanding is part of our relationship.

We sincerely hope that by sharing our financial expectations we will strengthen the physician-patient relationship and keep the lines of communication open. This financial policy helps us provide quality care to our valued patients. If you have any questions or need clarification of any of the below policies, please feel free to contact our billing department.

Payment is Due At the Time of Service

- We accept cash, checks, debit, credit cards and Care Credit.

Initial here _____

- All co-payments, deductibles, co-insurance and fees for non-covered services are due at the time of service unless you have made payment arrangements in advance of your appointment.

Initial here _____

- Insurance required co-payments are due when you check in for your appointment. If you arrive without your co-payment, we may ask you to reschedule. We charge an administration fee of $25.00 for co-payments not paid at the time of check in.
- If your co-payment is based on a percentage (example: 20% of the allowed payment) and you do not have a secondary policy, please be prepared to pay a minimum of $40.00 on the date of service.
- Patient-responsible balances are due when you check in for your appointment, unless prior arrangements have been made with the billing department.
- In the event you need surgery we will provide you an estimate of your insurance required deductible and co-insurance amounts.
- We request that at least **24 hour** advance notice be given to the office if you will be unable to keep your scheduled appointment. This allows us to release your appointment time to another patient. We charge an administration fee of $50 for no-shows. Patients who repeatedly "no show" for appointments may be discharged from the practice.

Proof of Insurance

- Please bring your insurance card(s) and a valid photo ID with you to each appointment.
- It is your responsibility to notify the Practice of changes in your health insurance.

Self-Pay Accounts

- We designate accounts, **Self-Pay**, under the following circumstances: (1) patient does not have health insurance coverage (2) patient is covered by an insurance plan that our providers do not participate in, (3) patient does not have a current, valid insurance card on file, (4) patient does not have a valid insurance referral on file or (5) patient declines to provide a social security number.

Initial here _____

- Self-Pay patients, please be prepared to pay a minimum of $210 on the date of service. There may additional fees for in office procedures, labs, x-rays, MRI, CT, crutches, splints, castings, DME or other supplies or services. If you are unable to pay, please ask to speak to the billing department to make payment arrangements.

Referrals

If you have an HMO plan we are contracted with, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, call your primary care physician to obtain it. Without an insurance required referral, the insurance company will deny payment for services. As such, if you are unable to obtain the referral at that time, you will be rescheduled or asked to pay for the visit in advance.

Financial Assistance

Our Practice treats patients regardless of financial status. We offer assistance in the form of a sliding scale discount of charges based on verifiable household income. The front desk receptionist will be happy to provide you an application.

Our Responsibility to Report Non-Compliance

It is our obligation under many of the insurance contracts to report patients who: repeatedly refuse to pay co-payments/deductibles at time of service, or who repeatedly "no show" for scheduled appointments.

Divorce and Child Custody Cases

- The parent or guardian who brings the child to the office for care is responsible for payment at the time of service no matter if the account is self-pay, participating insurance, or nonparticipating insurance. The Practice does not honor divorce specifics (*e.g., percentage of financial responsibility).*
- If the child has coverage with a participating insurance plan and the proper insurance identification is present at the time of service, the Practice will bill that insurance company. Applicable co-payments, coinsurance and/or deductibles are due at the time of service, unless arrangements have been made with the office prior to arrival.
- In cases of divorce, the individual who receives care is responsible for payment of co-payments, coinsurance, deductibles, and nonparticipating insurance balances at the time of service. We will not bill a divorced spouse for the patient's services.

Billing, Payments and Refunds

- If we must sent you a statement, the balance is due in full within 14 days of the statement date.
- If you cannot pay the balance in full with 14 days, please contact our billing department to see if you qualify for special payment options.
- It is your responsibility to notify the office of any change in address, phone, employment, or insurance coverage.
- If you make an overpayment on your account, we will issue a refund only if there are no other outstanding debts on other accounts with the same guarantor or financial responsible party.
- We reserve the right to report delinquent accounts to credit bureaus, assess a collection fee, take other collection action, or terminate you as a patient of this Practice.

Initial here _____ I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

Initial here _____ I authorize my insurance benefits be paid directly to **Rock Creek Neurosurgery, LLC.**

Initial here _____ I authorize **Rock Creek Neurosurgery**, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

Initial here _____ I authorize **Rock Creek Neurosurgery** to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Initial here _____ I authorize **Rock Creek Neurosurgery** to contact or discuss my personal health information with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

X Patient/
Guarantor Signature _____ Date: _____

Acknowledgement of Rock Creek Neurosurgery Notice of Privacy Practices

I hereby acknowledge that I have reviewed or received or have been given the opportunity to receive a copy of **Rock Creek Neurosurgery** Notice of Privacy Practices.

X Patient/
Guarantor Signature _____ Date: _____