SOUTHPARK INTERNAL MEDICINE

9088 S RIDGELINE BLVD #201 HIGHLANDS RANCH, CO 80129 P: 720.266.6900 F: 303.791.9920

Financial Agreement

For our patients with health insurance: SouthPark Internal Medicine will submit an accurate claim to all contracted insurances as a courtesy to our patients. This will require accurate information to be provided by the patient **at each visit** to ensure timely payment processing. Please remember that your health insurance policy is a contract between you and your Health Insurance Company, not between the Provider and the Insurance Company. If your insurance company requires you to pick a Primary Care Physician (PCP) and we are not the primary care physician (PCP) on your card, we will be unable to accept your insurance card. Should the patient not provide accurate insurance data then bill will become due by the patient at the time the insurance denies payment. I authorize payment of medical benefits to **SouthPark Internal Medicine** for services rendered. I understand that my insurance coverage may not provide payment for all charges incurred in obtaining treatment and I will be responsible for any co-payment, deductible, co-insurance or service not covered by my insurance. Paperwork requested for completion by SouthPark Internal Medicine will be charged on a page basis: 1-5 pages for $15.00 and 6 or more pages for $30.00.

If I do not have my insurance card with me today at my first visit, I will be responsible for my charges in full.

It is my responsibility to verify with my insurance company that any physician, lab or other medical provider or facility that I utilize participates in my provider "network" (e.g. HMO, PPO) prior to obtaining a service. Failure to do so may lead to lower benefits or non-coverage of services. No Out-Of-Network (OON) plans/benefits will be accepted.

Pre-Authorization Requirements: I understand that it is my sole responsibility to verify that pre-authorizations and/or referrals are in place prior to visiting the specialist or facility. I also understand that my insurance may require an office visit referral from my primary care physician to see a specialist. If a referral or authorization is not obtained prior to my appointment, I may be financially responsible for the charges incurred during the visits.

SouthPark Internal Medicine - <u>CANNOT</u> waive co-pays, deductibles, co-insurance, or non-covered service amounts defined as patient responsibility under the terms of our contract with the health insurance. Insurance will be verified prior to appointments. Co-pays are expected at the time of service and we may collect for office visits based on co-insurance and deductibles. Any remaining balance is expected upon receipt of a statement from our office.

For patients with no medical coverage: If you do not have health insurance coverage, payment for services is expected at the time of service. We offer a self-pay discount on the office visit only.

For auto accidents: SouthPark Internal Medicine <u>does not</u> bill auto insurance.

Missed/Cancelled Appointments: Missed appointments will be assessed a "no-show" fee depending on the type of visit. Appointments cancelled with less than 24 hour notice are considered a missed appointment and will be charged a no-show fee.

- Acute and follow up visits - **$50**
- Physicals - **$75**

Multiple missed or cancelled appointments may lead to patient dismissal from the practice.

Method of payment: We accept most major credit cards, checks or cash.

Past due accounts: All patient responsible balances will become delinquent 30 days after our request for payment. After 30 days you may be charged a billing fee for each month the account is past due. Any outstanding balances over 90 days may be turned over to an outside collection agency and you may be dismissed from the practice. If a financial hardship arises, please contact our Billing office at 720-266-6900 ext. 214.

Thank you for your understanding of our financial policy. If you have any questions regarding this policy or your account, please contact our Billing office at 720-266-6900 ext. 214.

I have read and understand the financial policy of the practice and I agree to its terms. I also understand that the terms may be amended by the practice.

_____ _____

Signature or patient / Responsible party Date

_____ _____

Please print Patient Name Date of Birth - required