Mountain Medical Center

PAYMENT POLICY

Thank you for choosing Mountain Medical Center (MMC) as your primary care provider. We are committed to providing you with high quality, affordable health care, and we strive to keep our prices representative of the usual and customary charges for our area. Please read the payment policy below regarding patient and/or insurance responsibility for services rendered, ask any questions you may have, and sign in the space provided. A copy of this policy will be provided to you upon request.

- **Insurance. 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.
- **Proof of Insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your 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.
- **Co-Payments. All co-payments must be paid at the time of service. We cannot bill them to you later.** This arrangement is part of your agreed upon contract with your insurance company. Failure on our part to collect co-payments from patients, while billing insurance, can be considered fraud. Please help us in upholding the law by paying your co-payment at the time of each visit.
- **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.
- **Non-Covered Services.** Please be aware that some – and perhaps all – of the services you receive may not be covered or not considered reasonable or necessary by your insurance company. You must pay for these services in full at the time of your visit (or as soon as your insurance company denies coverage of the services).
- **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 15 days to pay your balance in full. **Partial payments will not be accepted unless otherwise negotiated.** Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this it to occur, you will be notified by standard 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. If you have unusual financial hardship or other extenuating circumstances, please let us know that.

- **Missed Appointments. We charge $20 for appointments not canceled at least 24 hours prior to the scheduled appointment time. If you "No Show" for your appointment without calling us, there will also be a $20 fee charged.** These charges will be your responsibility and will be billed directly to you. Please help us to serve you better by keeping your appointments.

I understand I am financially responsible for all charges, whether covered or not covered by Insurance. I understand MMC may bill my insurance company for me if it is one with which they normally contract. If not, I understand that payment is due at the time of service. If I need to make special arrangements in regards to payment, I understand that I need to discuss this with the office staff. I understand a 30% collection fee will be added to my charges if sent to collection. Additionally, a returned check fee of $25 will be applied if a check is returned to us by the bank due to insufficient funds.

I request that payment of authorized insurance benefits, including Medicare benefits, be made either to me or on my behalf to MMC for any services furnished to me by the physician/provider/nursing staff. I authorize any holder of medical information about me to release any information necessary to process/pay the claim. If "Other Health Insurance" is indicated in item 9 of the HCFA 1500 Form, or elsewhere on the other approved claim forms of electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician/provider/supplier agrees to accept the charge determination of the Medicare Carrier as the full charge, and the patient is only responsible for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare Carrier. I permit a copy of this authorization to be used in place of the original. This authorization is in force indefinitely, until it is either cancelled or changed in writing by me.

I have read and understood Mountain Medical Center's Payment Policy and agree to abide by its guidelines.

Signature of Patient or Responsible Party **Date**