PATIENT FINANCIAL AGREEMENT

RE: **PATIENT NAME: _______________________________________ DOB: __________ SS#:_____________________________**

RESPONSIBLE PARTY/GUARDIAN:__________________________ DOB: ___________ SS#:____________________________

1. I understand that it is the policy of Mountain Family Medicine to submit claims for services performed on my behalf to my primary and secondary insurance company or governmental benefits agency, as long as I keep the office apprised of current insurance coverage for each office visit or upon any known changes to such coverage.

2. I understand that in addition to co-payments required by my insurance company or governmental benefits agency due to Mountain Family Medicine at time of check-in for services to be performed, any charges for additional services performed on day of visit or deductible amounts shall also be due and payable at time of check-out or as further stated herein. If I do not pay my account balances to Mountain Family Medicine in full when unreasonably past due, any future appointment may be cancelled and further service denied until payment is made or a payment plan is set up with the Billing Department.

3. I further understand that even if my insurance company or governmental benefits agency is billed by Mountain Family Medicine for services performed, I am financially responsible to the office for all charges, whether or not they are paid or reimbursed by my insurance company or governmental benefits agency. Further, I assign all applicable medical or government benefit funds and/or payments to Mountain Family Medicine for services performed. I authorize the release of any medical or other information necessary to process any claim for payments due.

4. I hereby agree to pay any account balances for services performed by Mountain Family Medicine within thirty (30) days if denied or not paid by my insurance company or governmental benefits agency or said balances may accrue billing fees or be turned over to a collection agency to process, at the option of Mountain Family Medicine.

5. I understand that if my account is assigned to a collection agency the collection agency will charge a commission or fee that may be as much as Thirty Percent (30%) of the amount I owe to Mountain Family Medicine. I agree that if my account is assigned to a collection agency, that Mountain Family Medicine may add the amount of the collection agency's commission or fee to the amount that I owe Mountain Family Medicine, and I agree to pay that additional amount.

6. I understand that the addition of a collection agency's fee or commission to my unpaid balance may well result in my owing a sum substantially in excess of the amount owed for medical services. I understand, for example, that if the unpaid balance that I owe to Mountain Family Medicine is $1,000, that Mountain Family Medicine may add up to $300 to my account, and I agree to pay the sum of $1,300 in such an event.

7. I understand that it is Mountain Family Medicine's policy that they will only turn an account over to collection if they are unsuccessful in reaching me as a patient or my responsible party by US Mail or via the phone numbers provided to make payment arrangements after my statement is over Ninety (90) days past due and internal collection processes are ineffective.

8. I understand that should my account be turned over to a collection agency, Mountain Family Medicine may also discharge me and any of my family members from the practice and refuse future treatment.

9. I understand and agree that in the event legal action is commenced to enforce my obligations hereunder, that I will reimburse Mountain Family Medicine for any court costs and reasonable attorney's fees.

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Signature of Patient or Responsible Party/Guardian Date Signed