INTERMOUNTAIN IMMC MEDICAL CLINIC™
Our specialty is you

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Welcome to Our Office!

Thank you for choosing Family Practice Group, P.A. dba InterMountain Medical Clinic as your health care provider. We are committed to providing the best treatment possible and making your experience with us a positive one. Please understand that payment for services rendered is considered part of your treatment. In order to best serve you, it is very important that you are aware of our financial policy as well as what your insurance policy will cover. The following is a statement of our Financial Policy, which we require all patients to read and sign prior to treatment.

Our office is currently contracted with the following: BlueCross, BlueShield, DMBA, Medicare, Medicaid, IPN, BrightPath, InterWest Health, Stratose and UPREHS.

Our Financial Policy

Payment is due at the time services are rendered unless payment arrangements have been made **prior to treatment**. We reserve the right to charge interest on past due accounts in the amount of **18% A.P.R.** as provided by state law. A processing/statement fee will be added to each visit in which you choose not to pay your portion at the time of service. Any returned checks will also be subject to a finance charge.

How do you know what portion of your bill is due at the time of service? Most insurance plans have either a deductible, which must be met before payment will be made, or a flat fee called a co-payment, which should be made with each visit. If you have not met your deductible (out of pocket expense), we may ask for payment in full at the time of service as no insurance benefit will be paid. If you have met your deductible your insurance should pay a certain percentage of your bill. We ask that your percentage of the charges, or your co-pay, be made at the time of service. If you do not know what portion you are expected to pay, we will ask for 20% of your bill. As stated above, if you do not pay your co-pay at the time of service you will be charged a processing/statement fee.

As a courtesy to you we will submit your claim to your insurance company. After a response is received regarding your claim, any unpaid portion becomes your responsibility. If your insurance plan covers more than what is expected, we will issue a refund check to you upon request. Please call your insurance company prior to your appointment and find out what your financial responsibility is for your visit. Providing us with accurate information will make the check-out process faster, more efficient, and allow us to obtain the quickest response from your insurance company.

Policy of Non-Discrimination: Our office does not discriminate in any manner contrary to law or justice on the basis of race, color, gender, sexual orientation, age, religion, disability, veteran's status or national origin in our acceptance of patients into the clinic.

Medicare and Medicaid Patients Accepted: We agree to provide reasonable access of care to government funded patients. Medicare and Medicaid accepted.

Access to Care: We are committed to providing medically necessary services to all patients, regardless of their ability to pay.

Please Continue reading on the back side, and then sign and date this policy agreement.

Wellness Physicals: Does your insurance plan cover wellness physicals? If you are not sure please call your insurance company prior to your appointment. If you are here for a wellness exam, please notify the doctor so your charges will be coded correctly.

Secondary Insurance: Having more than one insurance carrier does not necessarily mean that your visit will be paid in full. Secondary insurance carriers will pay as a function of what your primary carrier pays. We will submit your claim to your secondary insurance as a courtesy to you. You are responsible for any balances remaining after your insurance carriers have responded.

PPO Insurance: We may not be contracted with your PPO plan. This means that your insurance company may not pay the same rates as if a contracted provider saw you. If your PPO does not provide us with an EOB and you want us to submit to a secondary insurance, you are responsible for providing us with the EOB from your primary insurance. If unsure about our provider participation with your insurance, please see our billing department.

Worker's Compensation: If you are being seen for a work-related injury, please be sure to ask for a Worker's Compensation claim form when you check in. You will need to provide us with the name and address of your employer's insurance carrier.

Minor Patients: The adult accompanying a minor is responsible for payment at the time of treatment. Unaccompanied minors will be denied non-emergency treatment unless pre-authorized by a parent / guardian. Payment is still expected at the time of service.

Divorce Decree: This office is not a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The financial responsibility for minor(s) rests with the accompanying adult.

Third-Party Billing: Our office will not participate in any third-party billing. For example, if your charges are a result of a motor vehicle accident you are responsible for submitting your claim to the appropriate auto insurance company. We would be happy to supply the claim for your convenience.

Missed Appointments: Appointments missed without 24-hour notification will be noted in your account. At the discretion of the provider, you may be charged for missed appointments. Repeated missed appointments may lead to termination of services in our office.

Assignment and Release:

_____**Non Medicare:** I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any non-covered services. I also authorize the physician to release any information required to process this claim.

_____**Medicare:** I request the payment of authorized Medicare benefits be made to me or on my behalf to Family Practice Group, P.A. for any services furnished to me by that physician supplier. I authorize any holder of medical information about me to be release to the Centers for Medicare and Medicaid Services (CMS) and its agents regarding any information needed to determine benefits or the benefits payable for related services. This authorization is in effect until I choose to revoke it.

We look forward to being your health care provider. Please don't hesitate to call if you have any concerns or questions about this policy or our office. If you would like a copy of this policy to retain for your records, please ask a receptionist.

I have read, understand, and agree to follow the guidelines in this Financial Policy.

Signed and acknowledged: _____ Date _____