CHOICES IN HEALTH
Where leading-edge medicine meets innovative care

120 Old Laramie Trail East Lafayette, CO 80026 *Telephone: 303-444-0840 Fax: 303-444-0838*

FINANCIAL AGREEMENT

Thank you for choosing Choices In Health.

1. Insurance. We participate in most insurance plans, including Medicare. 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.
2. Co-payments, co-insurance and deductibles. All co-payments, co-insurance and deductibles must be paid at the time of service. The amount of deductible due will be 30% of estimated services. This arrangement is part of your contract with your insurance company.
3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance 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.
5. 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.
6. 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. I f your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

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7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account 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.
8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time
9. Medical Records Copying Charges: A service fee of $14.00 to $50.00 will be charged for copying your chart depending on the size.
10. Phone Calls: If you have an urgent need to speak to your provider, we will give you the soonest possible appointment. Our providers cannot give medical advice or test results over the phone.
11. Referrals: If Choices In Health is part of your insurance plan/network and you need a referral authorization from your primary care physician, it will need to be obtained before your appointment.
12. Legal Fees: Any patient sent to collections will be responsible for all collection fees. If a patient is taken to small claims court, the patient will be responsible for all fees/charges.
13. Prescription Refills: Our policy is for the patient to call their pharmacy and ask them to fax the request for your medication to 303-444-0838. Requests are handled within 48 business hours and processing times depend on your provider's availability.
14. Financial Responsibility and Payments: Our billing office, Flatirons Practice Management, can be reached at 303-546-3158. Ultimately, you are responsible for the payment of all tests and services rendered by Choices In Health. If you are having trouble with your insurance company, we understand. However, bills for services rendered that have not been paid in 45 days will automatically be sent to you.

I have read and understand the payment policy and agree to abide by its guidelines:

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Signature of patient or responsible party **Date**

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Printed Name

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