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FINANCIAL POLICY

We appreciate you considering our office for your medical needs. We realize that every person's financial situation is different. We have worked hard to provide a variety of payment options to help you receive the medical care you need. Proper medical treatment is an excellent investment in an individual's well-being, and you should be able to enjoy a healthy life while staying within your budget.

As a condition of your treatment by this office, financial arrangement must be made in advance. This practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment. Please read the following options carefully and choose the method of payment that will work for you.

Optional Payment Terms

- Option 1: **Cash Payment at time of service**: If insurance is not participating, services are paid in full at time of service under this option.

- Option 2: **Credit Card Payment at time of service:** If insurance is not participating, services are paid in full with a credit card (Master Card, Visa, Discover, or American Express) at time of service.

- Option 3: **Co-payments and Deductibles** at time of service: Patients who carry medical insurance understand that all medical services furnished are charged directly to the patient and that he or she is personally responsible for payment of all medical services. This office will help prepare the insurance forms for our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this medical office cannot render services on the assumption that our charges will be paid in full by any insurance company. A monthly statement showing all charges and payments on your account will be mailed to the responsible party of the account. We allow 90 days billing periods without adding interest charges to your account. All charges beyond 90 days will be assessed a 1.5% (18% annual) interest charge.

- Option 4: **Flex Spending/Cafeteria Plan Payments:** We require that you pay at the time of service. We will gladly provide the necessary information for you to submit to your flex spending/cafeteria plan In order for you to receive reimbursement.

1. a) In accordance with the FEDERAL TRUTH-IN-LENDING ACT, all doctors are required to give to their patients complete information in connection with the extension of credit.

   b) BASIC POLICY: The patient is responsible for all medical bills in our office. Our staff will with help completion of insurance forms as an accommodation and convenience to you without charge. It is the patient's responsibility to know your contract benefits, assure collection of insurance payments to us and to negotiate with your insurance company over any disputed claims.
2. WORKMAN'S COMPENSATION: In the event it is determined to be the Worker's Compensation board that the illness or injury is not a result of a compensated Worker's Compensation case, I hereby agree to pay usual and customary fees for services rendered.
3. REJECTED CLAIMS: If your insurance company rejects your claim, policy requires you to pay the balance in full upon receipt of your statement. If you cannot pay in full, contact our Business Office.
4. RETURNED CHECKS: A $20.00 handling charge is applied to all returned checks.
5. a) DELINQUENT ACCOUTN: Delinquent accounts over 90 days are turned over to our Collection Manager. If the bill remains unpaid and satisfactory arrangements for payment are not made and kept, a review of the account will decide appropriate legal action. All delinquent accounts will be charged an interest rate of 1.5% per month (18% per annum). If this account(s) is sent to collections the undersigned agrees to pay all remaining amounts due plus court costs, reasonable attorney's fees, a collection fee of 40% of the outstanding balance pursuant to Utah law, and interest thereon at the rate of 18% per annum. You authorize us to call you at any number you provide or at any number at

which we reasonably believe we can contact you, including calls to mobile, cellular, or similar devices for any lawful purpose. You agree to any fee(s) or charges(s) that you may incur of incoming calls from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us. In the event your account becomes delinquent and/or past due you expressly authorize this office, its' billing or collection company or companies which may be assigned, to use any contact information you have provided on any form or document to contact you. You expressly authorize us to contact you by telephone by sending text messages or emails at any number or email you have listed. Methods of contact may include the use of prerecorded artificial voice messages and/or the use of automatic telephone dialing systems as applicable. You acknowledge and agree that this authorization shall extend to any billing or collection company or companies which may be assigned. Furthermore, you understand certain forms of communication may not be secure and you accept that risk holding harmless this office, it's billing or collection company or companies which may be assigned.

b) If this account is assigned to an attorney or collection agency for collection and/or suit, the attorney or collection agency shall be entitled to reasonable attorney's fees, collection agency fees and court costs and interest at 1.5% per month.

6. MONTHLY STATEMENTS: You will receive an itemized monthly statement until your bill is paid in full whether or not you have insurance. This is a courtesy to you to help you be aware of the status of payments and charges on your account and have a record of services. This courtesy may expire at the will of this office, its' billing or collection company or companies which my be assigned. Once your insurance has paid, you are responsible for the unpaid balance. Interest of 1.5% per month (18% per year) will be applied to any amount not paid after 30 days with a minimum charge of 50₡ per month.
7. At the election of either you or us, any claim, dispute, or controversy ("Claim") by either you or us against the other, or against the employees, agents or assigns of the other, arising from or relating in any way to this Agreement or your Account, or any transaction on your account shall be submitted to binding arbitration. You further agree that no class actions, joinder or consolidation of any Claim, with a Claim of any other person or entity shall be allowable in arbitration, without the written consent of both you and us.

Payment Policies

All emergency medical services or medical services performed without previous financial arrangements must be paid for at the time of services are rendered. We accept payment for services in cash, ATM cards, and credit cards; MasterCard, Visa, Discover, American Express, Money Orders, and Traveler's Checks.

This medical office is not party to any divorce. In consideration for the professional services to be rendered by the doctor, NP, or PA to me, or at my request to my minor child or ward,, I agree to pay the fees charged for the medical services provided to the doctor, NP, PA, or his/her assignee at the time the services are rendered.

Broken Appointments

Your appointment is time that has been reserved especially for you, and we strongly encourage all patients to keep their appointments. If you must change your appointment or cancel, we request that at least 24 hour notice is given to our office to avoid a missed appointment fee of $25.00.

I, the undersigned, understand the above financial options and have chosen the method of payment that will work best for me. In the event of default and referral to an attorney or collection agency for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. I agree to pay all collection fees, which generally is approximately 40% of the existing balance, court costs, and attorney fees. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the doctor's collection agency or a collection attorney should collection procedures as described become necessary.

Patient or Responsible Party Signature Printed Name Date