EAGLE CREEK FAMILY MEDICINE

*Treating the **whole person** through **focused** individual care*

Patient Name:_____ DOB:_____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize Eagle Creek Family Medicine to release any information needed to my insurance carrier to determine benefits payable for related services. I hereby assign to Eagle Creek Family Medicine all payments for medical services rendered to me and/or my dependents.

MEDICARE

I authorize the holder of my medical information to release to the Health Care Financing Administration, and its agents, any information needed to determine these benefits.

Patient Signature:_____ Date:_____

Guardian Signature:_____ Date:_____

HIPAA - NOTICE OF PRIVACY PRACTICES

I have read and been offered a copy of the HIPAA Notice of Privacy Practices for Eagle Creek Family Medicine. **I have read and understand these policies.**

Patient Signature:_____ Date:_____

Guardian Signature:_____ Date:_____

1281 E Iron Eagle Dr. Eagle, ID 83616 T: (208) 939-5535 F: (208) 939-5536

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PATIENT FINANCIAL POLICY

We love taking care of you and your family. It is our desire to provide quality medical services at affordable prices. In order to accomplish this, we strive to operate our clinic efficiently.

INITIAL VISIT

Please provide us with current photo ID, insurance card and billing information if you would like us to bill your insurance for you. **All co-pays are due at time of visit**. If no insurance, payment in full is due at time of visit. We accept cash, checks, Visa and MasterCard. **We give 20% discount for full cash payments at time of visit.**

HEALTH INSURANCE

We will bill your insurance company as a courtesy to you. Each insurance company has its own rules for determining how much they will pay on each claim. We will try to answer any questions you have about your insurance, however, your policy is a contract between you and your insurance company. It is your responsibility to know your insurance policy and be familiar with your coverage. **You should contact your insurance company if you have any questions regarding coverage.** If your insurance company denies your claim you are responsible for payment in full. If you do not have insurance coverage, we are sensitive to your individual financial constraints so please discuss this with our billing department.

PAYMENTS

Copays are due at time of service. Unless we approve other arrangements, the balance on your statement is due upon receipt. If payment is not received, we reserve the right to refuse future appointments on delinquent accounts. **We charge 18% annually on accounts over 60 days**. Lack of action on your part will result in your account being sent to an outside collection agency and termination of care from our office. This will adversely effect your credit rating.

RETURNED CHECK POLICY

There will be a $35.00 fee for all returned insufficient fund checks and payments

NO SHOW OR LATE CANCELLATION

There will be a charge of $35 for all no shows and late cancellations. This not covered by your insurance.

I have read and understand this policy.

Patient Name:_____ DOB:_____

Patient (or Guardian) Signature:_____ Date:_____

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