Denver Family Medicine Financial Agreement

1. Payment for services is expected at the time of visit for those who do not have Medical insurance. A discount of 20% is applied to the physician office visit only. We cannot discount supplies, procedures, or laboratory services. A minimum deposit of $70.00 will be required prior to being seen and applied to your balance at the end of visit. Once services are completed, remaining balance is expected from patient or guarantor in full.

2. Insurance Co-Payments are expected at the time of service, as this is an agreement between the insured and their insurance company. You are responsible for knowing your co-pay amount. If you are unsure of your co-pay amount a standard $25.00 will be collected at the time of service. If your co-pay is less than $25.00 a credit will show on your account after insurance pays. If your co-pay is more than $25.00 you will be billed for the balance. If you need to be billed for a co-payment a billing fee of $5.00 will be added.

3. When balance statements are sent out, payment or payment arrangements are expected promptly.

4. If there is a financial hardship, please ask to speak to the billing department **before** an appointment is made to make payment arrangements.

5. If your account has a prior balance, any payment made will be applied to the **older balance first**.

6. Your account may be forwarded to an outside collection agency for failure to pay. The collection agency may report delinquency of payment to the credit bureau.

7. A service rendered by our providers does not guarantee payment by your insurance company. Please refer to your insurance benefit booklet or call the number listed on your insurance card for benefit information.

8. **Any lab/pathology service is billed separately from us**. Please refer back to your benefit information if you are unsure if lab/pathology services are covered by your insurance plan. Our doctors may recommend certain lab tests to be done on your behalf, this does not mean our office can guarantee these tests will be a covered benefit.

9. ***Any no-show appointments will be subject to a $25.00 charge***. We ask for 24 hours notice when canceling or rescheduling an appointment. If done under 24 hours you are subject to this fee.

10. Please direct all billing/financial agreement questions to our billing department at (303) 837-1061

I have read and understand the above financial policy.

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Revised 5/30/2017

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Patient Name (please print)

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Patient Signature or responsible party Date