Assignment of Benefits / Agreement of Financial Responsibility

Patient Name (Last, First, MI): ______________________

Patient date of birth (DOB): ______________________

Your health insurance policy is a contract between you and the insurance company. You have certain responsibilities to ensure that proper, accurate and timely submission of charges occurs. It is our policy to have you present your insurance card(s) at the time of every service visit. Please inform us as soon as possible if your insurance carrier changes and provide us with a copy (front and back) of your new card.

Copays are due at the time of service. If copay is not paid at the time of service, a $15 charge will be applied. (This will be waived if paid within 24 hours of the time of service). For returned checks, a $25 NSF charge will be assessed.

In order to avoid an unexpected bill from us, please know your policy benefits and coverage. Some procedures may not be covered or not covered at 100%, and certain services may fall into a different category of reimbursement with your insurance. Deductibles may come into effect depending on the services provided.

Cancellation / Missed Appointment Policy. A $20 charge will be assessed for a missed or cancelled appointment if a phone call is not made to cancel (or reschedule) the appointment within 24 hours in advance of the missed appointment. If for any reason you need to cancel an appointment, please notify our office as soon as possible. There will be a $20 missed / no show appointment charge billed to your account for missed or "no show" appointments.

In the event that you are unable to pay your balance in full and wish to set up a payment plan with us, please contact us to do so within 10 days of receipt of your statement. Failure to contact us within 45 days of the date of your statement may result in your account being forwarded to a third party for collection.

- In the event any amount(s) is/are referred to a third party debt collection agency I agree that in addition to any other amount(s) allowed for by law (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee as allowed by Utah Code.
- I hereby authorize said assignee to release all information necessary to obtain payment.
- I understand that I am financially responsible for all charges whether or not paid by said insurance.
- I have read, understood, and agree to the above financial policy for payment of professional fees.
- By signing below I agree to pay all amount(s) owed within 30 days when such amount(s) are incurred.
- I understand it is my responsibility to provide correct/updated insurance information.

Responsible Party Name (print): ______________________

Signature: ______________________

Date:______________________