South Denver Internal Medicine
A Concierge Medical Practice at Sky Ridge Medical Center
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FINANCIAL SERVICES AGREEMENT

The health insurance industry has grown more and more complex. Our financial policy is provided to help you understand your responsibility regarding charges incurred both in and outside of our office. **Please note: It is your responsibility to understand your group and individual insurance benefits.**

1. **Health Insurance Carrier:** If we participate with your health insurance carrier we will bill the insurance company for all charges for services rendered in our office. We will bill both your primary and secondary insurance plans (if applicable). You will be responsible at the time of service for the payment of:
   a. Charges applied to the annual deductible
   b. Co-payments You will be billed for services rendered in full should the insurance carrier deny coverage due to non-covered services, lack of referral, lack of proper reporting of incident/accident or lack of individual coverage.
2. **Medicare:** We are Medicare participating providers. We will bill Medicare directly for all charges for services rendered in our office. You will be responsible at the time of service for payment of:
   a. Charges applied to the annual deductible
   b. Co-payments
   c. Charges for non-covered services. You will be asked to sign a Waiver of Liability Form in the event that we know a service provided is not covered by Medicare. In the event that we are not aware of a charge that is not covered by Medicare, you will be balance billed after we obtain a denial from Medicare. You will not be balanced billed for charges for covered services.
3. **No Health Insurance:** If you have no health insurance, payment is expected in full at the time of service.
4. **Returned Check Fee:** In the event we receive a returned check due to insufficient funds, a fee of $35 will be charged to your account and payment is due upon receipt of your statement.
5. **Missed Appointment Fee:** We kindly request that you give us 24 hours notice if you are unable to keep your appointment. Failure to give 24 hours notice may result in a missed appointment fee of $50.
6. **Collection Fees:** In the event your account goes to collections, you will be responsible for all applicable fees. Should collections be necessary, any payment made to the collection agency via an electronic payment will incur a convenience fee. A convenience fee is a fee incidental to your payment obligation. Should litigation be necessary to collect an amount owed, the responsible party agrees to pay all costs of collection including, but not limited to, collection fees, attorney fees, court cost and interest at the rate of 18%.
7. **Collection Authorized Communication:** Should collection activity become necessary you authorize our office or agency acting on our behalf to call your residential, employment or wireless phone as a method of communication.
8. **Charges Incurred Outside of this Office:** It is your responsibility to schedule and perform requested laboratory studies, diagnostic studies, consultations and/or procedures that are performed outside of this office. Our office is not responsible for charges related to these services. Before and after receiving these services, it is your responsibility to address any issues regarding notification procedures or payment directly with your insurance company.
9. For your convenience **we accept** cash, checks, MasterCard, Visa, Discover and American Express.

Your signature below signifies that you understand this agreement and your responsibilities.

Signature: _____ **Date:** _____

Privacy Practices Notification:

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name: _____ **Date of Birth:** _____

Signature: _____ **Date:** _____