Hofmann Arthritis Institute
24 South 1100 East Suite, Suite 105
Salt Lake City, UT 84102

FINANCIAL POLICY AND AGREEMENT

Thank you for choosing us as your health care provider. We are committed to excellent patient care. The following is an explanation of our Financial Policy and Agreement, which you must read and sign prior to any current and future medical evaluation or treatment in this office. All patients must also complete the information and insurance form before seeing a provider. The content of this document may not be changed.

1. Each patient is responsible for his or her own bill.
2. Payment of all insurance co-payments and deductibles is required at the time medical services are rendered. A billing fee of $15 will be charged if you are unable to pay required co-payments on the day of service.
3. Patients who have no insurance are required to pay 100% of services rendered at each visit. If this is impossible you will need to make payment arrangements with our billing office prior to any medical evaluation or treatment. We accept cash, checks and major credit cards.
4. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and changes to our office. Your bill is your responsibility whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim.
5. You are responsible for knowing what your insurance covers and the providers and network(s) covered under your health insurance plan. Any service provided, but not covered by your insurance company, will be your responsibility to pay.
6. If your insurance company has not paid your full account within 60 days, you must pay the outstanding balance without further delay.
7. By signing below, you agree to pay all outstanding balances within net 30 days from date of **invoice** unless otherwise indicated above. (If applicable, HAI will not invoice patients until payment from insurances are received). A monthly finance charge of 1.5% per month (18% annual rate) will be charged to the amount not paid after 60 days, with a minimum charge of $.50 per month. The undersigned specifically agrees to pay all reasonable attorney fees and court cost in the event legal action is taken to collect on the account. The undersigned further agrees to pay an additional amount representing up to 40% of the principal balance if the amount is referred to a collection agency or attorney for collections. This additional amount is in recognition of the cost associated with said collection action processing.
8. Patients will be held liable for any damage done to the office.
9. A $25.00 fee will be charged on all returned checks.

USUAL AND CUSTOMARY RATES

Our rates for medical services reflect the usual and customary rates in the community. Unless we have accepted an alternate fee schedule from your insurance, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates for medical services.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize this office to release all information concerning my medical treatment to my insurance carriers and to requesting referring providers (if any).

ASSIGNMENT OF INSURANCE BENEFITS:

I further authorize and direct said agency, attorney or Insurance Company to pay from the proceeds of benefits of any recovery of insurance payments in my case, directly to the providers of this office, for their professional services rendered. I understand this in no way relieves me from my personal responsibility for paying my provider when a statement is rendered. It is understood that the signing of this form does not prohibit customary monthly billings.

NOTICE OF POLICY REGARDING ADVANCE DIRECTIVES: I understand that there are several types of advance directives; the two most common forms are living wills and a durable power of attorney designation. I understand that in the ambulatory care setting, if I suffer a cardiac or respiratory arrest or other life-threatening situation, signing this document grants consent for resuscitation and transfer to a higher level of care. Therefore in accordance with Federal law, HAI is notifying you that it will NOT HONOR previously signed advanced directives. If this is not acceptable to you, you must address this issue with your physician prior to performing the procedure.

HIPAA PRIVACY NOTICE: I acknowledge that I have received HAI's HIPAA PRIVACY notice and have had the opportunity to review its content. _______ **(please initial)**

*Signature of Patient or Responsible Party*____________________________________ *Date*_______________