Gunnison Family Medical Center

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FINANCIAL POLICY

ABOUT FINANCIAL ARRANGEMENTS AND HEALTH INSURANCE

We are committed to providing you with the best possible care. If you have medical insurance, we will work with you to help you receive your maximum allowable benefits. In order to reach these goals, please read and understand our payment policy.

Payments for services, including co-payments, are **DUE AT THE TIME OF SERVICES** and are rendered unless payment arrangements have been made and approved, with a signed Payment Agreement, on file. We will be happy to help you process your insurance claim form for your reimbursement.

We will gladly discuss your proposed treatment and answer any questions relating to you insurance. **HOWEVER, PLEASE REALIZE THAT:**

- Your insurance is a contract between you and/or your employer and the insurance company. We are not a party to that contract **(WITH A FEW EXCEPTIONS, INCLUDING MEDICARE, MEDICAID, ROCKY MOUNTAIN PPO, ANTHEM BCBS, GREAT WEST, SLOANS LAKE/COFINITY, AND SLOANS LAKE/COFINITY ADMINISTERED AETNA PLANS).** You are responsible for providing us with current, accurate insurance information in the form of a card within 48 hours of your appointment. If you do not provide this information in the time to comply with your insurance carrier's timely filing requirements, you will be responsible for payment in full.
- Our fees are generally considered to fall within the reasonable and customary range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage **(SUCH AS 50% OR 80%)** of usual, customary and reasonable determined by most insurance companies.
- **NOT ALL SERVICES ARE COVERED BENEFITS UNDER ALL CONTRACTS.** Some Insurance companies designate certain services they will not cover. We will gladly call for pre-certification, but it is important to understand that this does not guarantee payment. You are responsible for obtaining the necessary referrals and we will assist you with that process if necessary.

We emphasize that as health care providers our relationship is with you, not you insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account.

By my signature below, I acknowledge that I have read and understand the above and that I have been advised that if it becomes necessary to use an outside collection agency to secure payment of the balance due, a 30% fee will be added to my account. I thus agree to pay all costs of collection, including attorney fees and waive my exemption under the constitution of laws of the state of Colorado.

If you have any questions about the above information or any uncertainty regarding insurance coverage, Please Ask Us.

_____ _____
Patient Name (Please Print) Date of Birth

_____ _____

Patient Signature Date