Riverton and Zenith Family Health Office Policies

FINANCIAL POLICY

I. RESPONSIBLE PARTY

a. RFHC will gladly submit claims to your insurance for the services provided. However, charges accrued on the account are *your responsibility*. You will be expected to follow up on any unpaid or incorrectly paid charges, regardless of insurance coverage. We will be happy to assist you in any way we can, but ***you are ultimately responsible for timely payment of your account. You are responsible for payment-in-full if your insurance company does not pay us within 90 days.***

b. You will be responsible for charges accrued by children who have turned 18 until such time as you notify RFHC in writing, prior to services being provided, that you no longer accept financial responsibility.

II. BILLABLE SERVICES

a. RFHC will charge for all appointments and supplies used. We will also charge for patients who are not scheduled (i.e., siblings of a scheduled patient) that the physician is asked to see.

b. RFHC will charge for all follow-up services. The same resources (staff, room, supplies, physician time, etc.) are used for the follow-up visit.

c. Occasionally a patient will be scheduled for one type of service but the physician may diagnose and treat another problem in addition to the scheduled service. When appropriate, RFHC will charge for the additional service. Some insurance companies will not cover both services, which may result in denial or higher copay.

d. RFHC reserves the right to charge $50 for missed appointments. This charge will not be billed to your insurance company, but will be your responsibility. To cancel existing appointments, please notify our office at least 24 hours prior to your scheduled appointment time.

III. PAYMENT DUE AT TIME OF SERVICE

a. If you have insurance coverage, all co-pays, co-insurance, and deductibles are due at the time of service. An additional $20 fee will be added if you fail to pay your co-pay at the time of service.

b. A $50 deposit is due at each appointment check-in for self-pay patients. Payment in full is due from self-pay patients at the time of service. A discount will be given when charges are paid in full on the date of service.

c. RFHC reserves the right to charge a statement fee for any amounts that become past due and require additional statements to be sent.

d. RFHC may present charges to you by written statement following a visit. If we do this, we expect that each charge will be paid in full by return mail the first time it is presented to you. We may send you statements and reminders of charges, or we may call you about the same. By accepting our services, you are consenting to receive these communications.

e. If you do not agree with patient responsibility amounts or reimbursement amounts set by your insurance, this is a matter between you and your insurance company. We are happy to provide you with factual information about your care and billing to help you discuss this with them, but we still require you to promptly pay the entire charge we present to you, even if your issue with the program is not resolved.

IV. INSURANCE COVERAGE

a. It is your responsibility to provide accurate insurance information to RFHC at the time of service.

b. RFHC will create and submit claims to your insurance on your behalf. However, we reserve the right to refuse insurance and collect payment in full from you (i.e., insurance information provided after claim filing deadlines, etc.).

c. It is your responsibility to verify benefits under your plan. You will also be responsible for amounts not paid by your insurance for any reason, unless the amounts are covered under RFHC's contractual agreement with insurance.

d. RFHC must, under federal law, accurately report the services provided to you. Your insurance company may not pay for all services received. RFHC cannot change the service or diagnosis codes (unless they were initially reported incorrectly) in order to make a service "fit" your insurance plan benefits. We must report the exact services provided and the exact reason for providing them.

e. Your signature on this policy authorizes RFHC to release health information to insurance carriers when necessary for payment, and directs them to remit payment directly to RFHC (assignment of benefits).

V. CREDITS

a. Any insurance credits or over-adjustments will be returned to the appropriate insurance company.

b. Any patient credits or overpayments will first be used to pay past-due balances, including those which may have been referred to an outside collection agency.

c. If patient balances have been resolved, patient credits will be returned. Please allow 4-6 weeks for processing. Smaller credits (generally under $25.00) may be left on the account to be used for future co-pays and/or deductibles.

VI. COLLECTIONS

- **a.** By signing this form, you agree to receive texts concerning the billing status of your account.
- **b.** Your account may go to collections for the following reasons that include but are not limited to:
  - **i.** Invalid patient demographic information (address, phone, etc.) which prevents us from contacting you regarding your account.
  - **ii.** Failure to provide timely, accurate insurance information.
  - **iii.** Failure to pay patient balances.
  - **iv.** Failure to follow through with statement discrepancies, insurance denials or any other items on your account.
  - **v.** Failure to follow through with other correspondence from RFHC.
- **c.** RFHC makes every effort to work with you to keep your account out of collections. However, in the event that your account is referred to a third party debt-collection agency, you will be responsible for the balance of the account in addition to a 30% collection fee and any other amounts allowed by law (interest, court costs, attorney's fees, etc.), as allowed by Utah Code Annotated section 12-1-11.
- **d.** Utah Law requires health care facilities to provide patients and/or responsible party(ies) with notice, by certified mail, priority mail, or text message, 45 to 60 days prior to placing any delinquent balance with a collection agency or reporting and delinquent balance to any credit bureau. Such actions may negatively impact the responsible pary(ies) credit score. A $15.00 fee will be charged if any such notice is sent.

MEDICAL RECORDS/ HIPAA COMPLIANCE ACKNOWLEDGEMENT

I. Our written Notice of Privacy Practices provides detailed information on how we may use and disclose your protected health information. According to HIPAA provisions, you have the right to review a copy of this notice prior to signing this form. You also have the right to receive a printed copy of the privacy notice if you so desire, and is available upon your request. If necessary, a legal guardian or authorized representative should sign. This clause authorizes the doctor to release any medical information that may be used for the following purposes: Treatment, Payment, and Operations, and at times when the doctor deems it necessary in order to ensure the best medical care on your behalf. We are required by law to maintain your confidentiality of any health information that identifies you. We are committed to protecting your privacy. This is an ethical and legal obligation that we owe to our patients. Your signature is required to be compliant with HIPAA. Any person that receives these medical records is not authorized to release any of the information obtained by this authorization to any other person or organization without a further authorization signed by you for the release of this information. A fee will be charged to the patient or third-party requesters for copies of medical records.

PRESCRIPTION

I. All prescriptions for controlled substances, antibiotics, new medications not formerly given by RFHC, and established medications require an office visit. The provider will prescribe enough medication to last until they would like you to follow up. When you pick up your last refill from your pharmacy, please call our office to schedule your follow-up appointment.

II. By signing below, you grant RFHC/ZFHC permission to view your prescription history from external sources.

Thank you for trusting Riverton/Zenith Family Health Center with your care. We are dedicated to making your experience a positive one. Please do not hesitate to contact us with any questions regarding your account, payment options, or financial responsibilities.

[ ] I have read and understand the above policies, and I will be financially responsible for the following patient:

_____ _____ /_____ /_____

PRINT Patient Name — Patient's Date of Birth

_____ _____

PRINTED name of Legal Guardian, if other than patient — Relationship to Patient

_____ _____ /_____ /_____

Signature — Today's Date