Patient Last Name	Patient First Name	M. I.	Patient Date of Birth

You are valued as a patient within our practice, and we feel it is important to keep you informed that there are ongoing changes in the healthcare industry. These changes may affect you in the services that you may receive that are covered by your insurance carrier, or in services that you receive that are determined to be due and payable directly by you.

Cancellation and No-Show Policy

If you do not call to cancel your appointment prior to 24 (twenty-four) hours from your appointment, are more than 10 (ten) minutes late or do not show for your scheduled appointment, you may be charged up to a $50 late cancellation fee. Repeated late cancellations and/or no shows may lead to termination.

Insurance Identification

We will make every effort to properly identify your coverage and to submit claims on your behalf to your insurance carrier to obtain their prompt payment. The terms of your insurance coverage may limit the specialists you see and what hospitals and laboratories you need to use. **Please assist us in helping you to meet the terms of your coverage by presenting your current insurance card at every visit.**

Non-Covered Services

The terms of your insurance coverage have specific guidelines that indicate services that are covered and services that are not covered under your health insurance policy. It is possible that your insurance may not cover services that our physicians feel to be necessary in maintaining your health. We ask that you become familiar with your insurance policy and identify for your own knowledge services that are not a benefit of your policy.

Preventative Health Services

Preventative health services, such as annual exams, well woman checkups, complete physical exams, etc., vary in coverage from carrier to carrier. There are many carriers who do not provide benefits for routine care and preventive medical services. We feel strongly that screening for a potential health problem is an essential component of maintaining your health and do request that you schedule and receive these important services when recommended by your physician. It is your responsibility to understand the terms of your policy with regards to preventative and routine services. **Management of past or current health problems or treatment of new problems discovered during your physical may result in an office visit copay or deductible**. We will bill you after the insurance processes your claim.

Telehealth

Colorado Physician Partners is pleased to provide an option for patients to see their provider virtually through a secure video platform. Virtual visits (telehealth) use telecommunications technology to provide real-time health care to patients. Virtual appointments must be approved by your PCP. Telehealth visits may not be a benefit of your insurance policy and you may be liable for the service performed. Patients will be liable for charges which may include co-pays, co-insurance and/or deductibles for this service.

Non-Physician Services

There may be times within our practice when you receive services such as injections, blood pressure checks, drawing of blood for evaluation of a condition and not see a physician directly on the same day. These nurse services are processed as a minimal office visit within our practice as outlined under the American Medical

Association's current procedural guidelines for correct coding procedures. Some insurance carriers do not require patients to make co-payments for minimal office visits. However, there are some that do require a co-payment from you for these services. If your insurance carrier is one that requires co-payment for minimal office visits, you may be billed for this later.

Copayments, coinsurance, deductibles, and non-covered services

All out of pocket expenses, which are based upon the terms of your coverage, are due and payable at the time services are rendered. **Co-Payments, under the terms of your coverage, must be paid at the time of service. Patients that have not met their deductible will be required to pay $75 at the time of service.** We do require that patients without health insurance coverage, make full payment or payment arrangements at the time of service. Our billing office will submit to you a statement of your balance due based on the information we receive from your insurance carrier. If you disagree with their determination, you will need to contact the insurance directly.

Patient Paperwork

Please note that paperwork completion may incur a fee of $30.00 or more. The fee must be paid when you pick up your documents.

Insurance claims are filed as a courtesy, but it is my responsibility to see that the claims are paid.

- ***I understand that I am responsible for payment of fees not covered by insurance.***
- ***I assign all benefits to the billing provider and Colorado Physician Partners.***
- ***I authorize the submission of claims without obtaining my signature on each claim submitted.***
- ***I give my authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my doctor.***

I understand that responsibility for payment of medical services in this office for myself and my dependents is mine; due and payable at the time of services are rendered unless financial arrangements have been made. If my account becomes delinquent, I understand I may receive statements, emails, texts or calls regarding the past balance. I understand that I am responsible for all costs of collection including attorney fees, collection fees of 30% and court costs, if sent to an outside collection agency. I authorize communication by telephone, email or other means, should my account default and/or be sent to an outside collection agency. I understand that any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly).

My signature below indicates that I have been provided the opportunity to read the office financial policy and ask questions, and that I agree to comply with this policy in providing payment for services rendered.

_____ _____

Print Patient Name/Representative | Relationship to Patient

_____ _____

Patient/Representative Signature | Date