

PATRICIA BEARNSON, M.D.P.C.

**FINANCIAL POLICY AND AGREEMENT**

Thank you for choosing Patricia Bearnson 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 medical evaluation or treatment. All patients must also complete the information and insurance form before seeing a physician.

1. Each patient is responsible for her/his own bill. We accept cash, checks, Master Card, Visa and American Express.
2. Payment of all insurance company co-payments are required at the time medical services are rendered. If you are unable to pay for today's services, we will be happy to reschedule your appointment.
3. Patient's who have no insurance are required to pay 100% at the time medical services are rendered. Please contact the office manager prior to your appointment so you can better understand the approximate cost and determine how payment can be made.
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. If your insurance company has not paid your account in full within 60 days, you will be notified by our office. You may contact your insurance company to determine why payment has not been made. If we have not heard back from you with 7 working days, we will charge the balance to your credit card.
6. A \$15.00 fee will be charged on all returned checks.
7. In the event that full payment for charges incurred in my medical care is not made. I agree to pay all costs of collection, including 33 1/3% Collection Agency Commission, reasonable attorney fees and interest at the rate of 21% per annum. I also agree to subject myself to the jurisdiction of the courts of Utah.

**Authorization to Release Information**

I hereby authorize Patricia Bearnson M.D. to release all information concerning my medical condition treatment to my insurance carriers or referring physicians (if any).

X \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Patient

**Authorization to Pay Benefits**

I hereby instruct and direct \_\_\_\_\_ Insurance Company to pay by check made out and mailed to:

Patricia Bearnson M.D.P.C.  
1434 East 4500 South, suite 102  
Salt Lake City, UT 84117

If my current policy prohibits direct payment to the physician, then I hereby also instruct and direct my insurance company to make out the check to me and mail it directly to Patricia Bearnson M.D.P.C. for deposit. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. I agree to pay any charges which I am responsible for that my insurance does not cover.

X \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Policyholder or Claimant