PATRICIA BEARNSON M.D. P.C.

FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of bills we send to you. The following is a summary of our payment policy.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and co-payments for participating insurance companies. We accept cash, personal checks (in-state only), VISA, MasterCard and American Express. There is a $35 service charge for returned checks.

Patients with an outstanding balance 60 days or more overdue must make payment arrangements for payment prior to scheduling appointments. The billing department can be reached at (801)878-7103.

INSURANCE:

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and co-payments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier.

If you need assistance or have questions, please contact the billing department at (801)878-7103.

REFUNDS:

Patient/guarantor credits in amount of $40.00 or less will be retained on account to be credited toward future balances unless a written request for refund is received. Amounts greater than $40.00 will automatically be refunded to the patient/guarantor.

MISSED APPOINTMENTS/LATE CANCELLATIONS:

Broken appointments represent a cost to us, to you and to our other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read and understand the Financial Policy. I hereby authorize assignment of insurance benefits to Patricia Bearnson, MD and also authorize Patricia Bearnson, MD to release all information concerning my medical condition and treatment to my insurance carrier and/or referring physician whenever necessary for my patient care and/or payment of insurance claims. In the event that any amount(s) is/are referred to a third party debt collection agency, I agree that in addition to any other amount(s) allowed for by law, (interest of 10%, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 25% of the principal amount(s) owing as allowed by Utah Code Annotated, sec. 12-1-11. The terms of this paragraph shall apply to all amount(s) incurred by me or by an individual for whom I have legal responsibility whether such amount(s) is/are incurred today or after today.

Signature of insured or authorized representative: ____

Date: __________________________