Boulder Community Health
Ambulatory Services Department

Clinic Name*:**_____Provider*:**_____

Financial Policies

Please read and sign, indicating your understanding of the following information. If you have questions please do not hesitate to ask. It is important that you understand these specific policies of the Boulder Community Hospital Physicians' Clinics and that you understand how your insurance company will handle your claims.

_____ **It is your responsibility to provide the office with current and correct insurance information.** Failure to do so could result in your insurance company rejecting your claims for failure to obtain authorization or timely filing. In the event that this should happen you will be responsible for the incurred charges.

_____ **It is your responsibility to verify your coverage and adhere to the restrictions of your plan.** The clinics participate with most major medical insurance companies. However, Insurance companies frequently specify the time frame in which patients can be seen and the coverage widely varies group to payor. If appointments are made that are not covered by your insurance plan, you will be responsible for payment.

_____**We do not always know if you have a deductible, if your deductible has been met, or if you have co-insurance.**. It is your responsibility to know this information. You are responsible for all charges that are not paid by your insurance company, including those applied to your deductible or co-insurance.

_____ **You will need to sign a self-pay waiver if you have no insurance.** This waiver clarifies your financial responsibility and helps prevent misunderstandings.

_____ **Discounts are offered on some medical services, but ONLY if you pay at the time of service**. If you have no insurance, or if you are receiving services that are not covered by your insurance plan, you may be eligible for a discount on ***some medical services***. Payment must be made at the time of service for the discount to apply. The front office staff can let you know if the services you are receiving qualify for the discount. It is your responsibility to ask the front office for the discount.

_____ **If you have a co-pay, you are expected to pay this when you check in for your visits.** Most insurance companies assign a co-payment to the patient and it is our responsibility to collect this at the time of service. We take checks, cash, and credit cards. Be prepared to pay your co-pay when you check in for **each** visit.

_____ **You will be charged if you fail to show up for your appointment or if you cancel your appointment with less than 24 hours notice.** Exceptions may be made for inclement weather. The correct number to call when canceling an appointment is 303-441-2347.

_____ **There may be services that are initiated during a clinic visit that are <u>not</u> performed on-site and are <u>not</u> billed by the clinic directly** (for example, most laboratory, pathology, and radiological diagnostic services). When services and diagnostics are sent out to a third party, you will receive a separate bill from that third party directly for any patient balance that is due. If you want additional information, it is your responsibility to ask at the time of service, whether services are being sent out and to whom they are being sent.

_____ **I consent to be contacted by regular mail, e-mail, or telephone (including wireless/cell number) regarding any matter to my account(s).** This consent applies to all BCH healthcare providers and/or any entity working on behalf of BCH. This consent includes any updated or additional contact information that I may provide, and includes phone calls that employ auto-dialer technology and prerecorded messages. If I wish to revoke this consent, I agree to provide notice of that revocation by contacting BCH Patient Financial Services at 303.415.4766

I understand that BCH Physician's Clinics will need to use and disclose certain medical information about me as it relates to my treatment, payment for treatment, and healthcare operations. I have been provided with a notice that describes how my medical information may be used and disclosed and how I can access this information.

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Signature of Patient or Legal Guardian **Date**