ENSIGN
Family Medicine, LLC
5771 S. Fort Apache Rd. # 100 Las Vegas, Nevada 89148
(702) 951-3400

FINANCIAL POLICY

Patient Information: All patients must complete our patient registration forms prior to their initial visit with the doctor. It is your responsibility to keep our office informed of any changes in information (i.e. change of address, phone number, insurance information). If we are not notified of changes to your personal information at the time of service, you will be billed for the services.

Payment Information: Payment is due at the time of service. Accepted forms of payment are Visa, MasterCard, cash and personal check. All applicable co-payments, co-insurance , and deductibles will be collected prior to your visit. A $10.00 late fee will be charged to any fee not paid at the time of service. If we are not contracted with your insurance company or if the patient does not have insurance coverage, payment must be made in full at the time of visit. Our fees for medical care are based on the usual, reasonable and customary fee charges in this area by physicians of equal training and experience.

Returned Check Policy: Writing a bad check is against the law. There is a $25 fee for all returned checks. If we receive a returned check, you must pay the balance, including the fee, with Visa, MasterCard or cash only.

Insurance Information: As a courtesy to our patients, we will bill your insurance company. In order to do so, we must have updated and accurate insurance information. Please be aware that your insurance policy is a contract between your and your insurance company. It is your responsibility to know the rules and regulations of your plan. Your account with this office is your responsibility whether or not your insurance company pays. We will do all we can to assist you with your healthcare claims. If we do not receive payment from your insurance company within 60 days from the date of service, the balance of the account will be your responsibility. A detailed receipt will be provided for all services paid.

Collection Policy: We will make three (3) attempts via mail to notify you of any unpaid balance on your account. It is important that you keep our office notified of any changes to your personal information (i.e. address, phone number). If an account remains unpaid after ninety (90) days, the account will be referred to a collection agency and a $25.00 collection fee will be charged.

Missed Appointments: Twenty-four (24) hours notice is required for changes to a scheduled well or routine visit. A $25.00 fee will be charged to your account if proper notice of cancellation is not received.

Having read the above, I hereby authorize payment by my insurance carrier, or state program, or other designated payor of medical benefits to Ensign Family Medicine for services furnished to me. This assignment will remain in effect until revoked by me in writing. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage. A photocopy of this assignment is as valid as the original.

_____ _____
Patient Name (please print) Date of Birth

_____ _____
Signature of Patient or Responsible Party Date **Authorization expires 12 months from the date signed**

HIPPA AUTHORIZATION

Besides yourself, whom may we disclose your medical information to?

NAME(S) RELATIONSHIP

_____

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Ensign Family Medicine at the address above. The revocation will be effective only upon receipt , except (1) to the extent Ensign Family Medicine has acted in reliance on the authorization, or (2) the authorization was obtained as a condition of obtaining insurance coverage and the insurer wished to use the protected health information to lawfully contest a claim.

I understand that treatment by Ensign Family Medicine is not conditioned on my signing this authorization, although exceptions will be made for (a) research-related treatment, (b) for treatment the purpose of which is creating protected health information for a third party, such as pre-employment physicals, and (c) except for psychotherapy notes, for health plans who condition enrollment or on an authorization requested prior to enrollment, or where payment is conditioned on authorization to use PHI to determine payment.

_____ _____
Patient Name (please print) Date of Birth

_____ _____
Signature of Patient or Responsible Party Date **Authorization expires 12 months from the date signed**