IDAHO HAND INSTITUTE

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have had an opportunity to review a copy of the Idaho Hand Institute (IHI) *Notice of Privacy Practices*. I understand that IHI has the right to change its *Notice of Privacy Practices* from time to time and that I may contact IHI at any time to obtain a current copy of the *Notice of Privacy Practices*.

_____

Patient Name (please print)

_____

Signature of patient, Legal Guardian, or Legal Representative

_____

Relationship to Patient

_____

Date

FOR OFFICE USE ONLY

I have attempted to obtain the patient's signature on this form, but was not able to for the following reason:

_____

_____

_____

_____

_____

Initials: _____ Date: _____

Thank you for selecting Idaho Hand Institute for your upper extremity needs!

FINANCIAL POLICY – Please read

BASIC POLICY: As a patient you are responsible for all of your medical bills in our office. It is your responsibility to provide current and correct insurance information to us, to know your insurance contract benefits, to ensure your insurance company pays for your care, and to negotiate disputed claims with your insurance company. We ask that you notify us of changes to your address, telephone number, insurance, or other contact information. A fee of $25 may be applied for missed appointments if prior notice is not provided. Our business office is available Monday through Thursday from 8:30 AM to 5:00 PM and Friday from 8:30 AM to 12:00 PM to address any concerns or questions you may have.

IF YOU DO NOT HAVE HEALTH INSURANCE OR YOUR INSURANCE INFORMATION: According to the Affordable Care Act of 2010, you are required to purchase health insurance or pay a fine. Payment in full is required at the time of service if you do not have insurance or your insurance information. If you cannot pay in full today you are required to meet with our financial counselor to arrange a partial payment and a payment plan. We require a valid credit or debit card on file. At your request we will suggest an insurance agent who can provide you with information to purchase an insurance policy. You may not receive a self-pay discount and then ask us to file the claim with your insurance at a later date.

IF YOU DO HAVE INSURANCE: Please present your insurance card to the receptionist at the time of your appointment; a copy will be placed in your medical record. Your co-pay or $30, along with your estimated portion, including any applicable deductibles, will be due at the time of service. We will attempt to bill your insurance provider, who should send an Explanation of Benefits to you.

REFERRALS: If you are insured by Medicaid, a referral from your primary care provider is required. If you are insured by Indian Health Services, a signed referral from Contract Health is required. If you participate in a Connect health plan (HMO), a referral from your primary care provider is required. If you purchased a health plan through the exchange, a proof of premium payment is required. These referrals are required by your insurance company and must be provided or your appointment may be rescheduled.

WORKER'S COMPENSATION: If the Worker's Compensation board determines that your illness or injury is not a result of a compensable Worker's Compensation case, we will bill your private insurance. The balance will be your responsibility.

LIABILITY: If you are pending settlement from an insurance company or attorney, monthly payments of at least $25 will be required until a settlement is received.

MINOR PATIENTS: The parent, guardian, or adult accompanying a minor is responsible for full payment of all applicable charges. Unaccompanied minors will be denied non-emergent treatment unless pre-authorized by a parent or guardian.

REJECTED OR PARTIALLY PAID CLAIMS: If your insurance company rejects your claims, or they pay less than the total charges, you may be responsible to pay the balance in full upon receipt of your statement. If after the insurance payment you are unable to pay in full, please contact our business office to make payment arrangements.

MONTHLY STATEMENTS: Whether or not you have insurance you will receive an itemized monthly statement until your bill is paid in full; please make your payment within 30 days of receipt unless you have been approved for a monthly payment plan. If you disagree with the charges or balance or you have questions, please contact our business office.

FORMS OF PAYMENT: We accept payments in the form of cash, check, money order, debit card, American Express, Discover, MasterCard, and Visa. We also accept Care Credit. Under certain circumstances payment plans may be negotiated in house for balances less than $200 for up to six months.

RETURNED CHECKS: You will be charged a $20 fee for returned checks.

DELINQUENT ACCOUNTS: A charge of 18% APR may be applied to balances over 90 days. Delinquent accounts over 90 days are turned over to our billing supervisor. If satisfactory arrangements for payment are not made, the account will be submitted to a collection agency.

FORMS FOR YOUR INSURANCE: At times your insurance provider may require or request the completion of certain documents and forms. We will complete these forms for you at the charge of $3 per page.

PLEASE CALL OUR OFFICE IF YOU HAVE ANY QUESTIONS AT (208) 235-4263

My signature below affirms that I have read, understand, and agree to this Financial Policy. I hereby guarantee payment of all charges for the medical treatment and services provided to me (or to my dependent) by Idaho Hand Institute. Idaho Hand Institute reserves the right to make necessary changes to its financial policy as the need arise. The most recent version of this financial policy can be found at idahohandinstitute.com.

PATIENT: _____ DATE: _____

PERSON RESPONSIBLE FOR THE ACCOUNT: _____