HEIDI HERAS, MD
ears, nose & throat specialist

Financial Agreement

EARS • NOSE • THROAT • WWW.DRHEIDIHERAS.COM

Thank you for choosing Dr. Heidi Heras as your health care provider. We ask that you please understand that payment of your medical bills is necessary in order to keep health care accessible. The following is a statement of our financial policy, which we require you read and sign prior to any treatment.

If we are a participating provider with your insurance plan, we will take assignment of insurance benefits from that plan. All co payments, deductibles and coinsurance amounts are due at the time of service. A billing fee of $25.00 will be assessed to all amounts that are not paid at the time services are rendered. Amounts that that cannot be anticipated at the time of service will be billed once without penalty to the patient upon receipt of the insurance payment.

In the event that payment in full for charges incurred is not made the undersigned agrees to pay all costs of collection including a 50% collection fee (minimum collection fee $25.00), attorney fees, court costs and interest at the rate of 1.5% per month (18% per year).

In the event that we are not participating with your insurance plan, payment is expected at the time of service. We will be happy to provide you with all the necessary information for you to submit your claim to your insurance carrier to pursue reimbursement. Your insurance policy contract is between you and your carrier, please be sure that you understand your insurance policy coverage prior to your appointment.

If the patient is a minor and the parents/legal guardians are divorced/separated, regardless of who brings the child to the office visit I am responsible for payment on the account. We apologize, but we are unable to bill two separate parties for balances. If the parents/legal guardians would like the account to be assigned to a designated parent/legal guardian that person must be present at the office when signing the financial agreement and then give rights (if needed) to the other parent to records or billing information of the patient. We are unable to bill third parties such as ex-spouses.

I understand that it is my responsibility to inform Dr. Heras' staff of any changes in my address, phone numbers and or insurance coverage in a timely manner. We do not take the responsibility for claims denied for termination or change in coverage. Often, these denials come to us after the allowed submission period for the new insurance has passed. Under these circumstances, the patient will be held responsible for payment in full for services rendered, regardless of our status with that carrier as a provider. We do not bill third insurances or automobile insurances, but will be happy to provide you with forms that you can submit for the charges. Payment will be expected at the time that service is rendered for auto accident claims not covered under primary and secondary medical plans.

If complete payment cannot be made at the time services are rendered, definite arrangements for payment must be made at that time. We cannot extend a line of credit through our office; however we will try to be as helpful as possible in determining the most convenient payment options for you. I agree to pay a monthly service fee of $5.00 for any balance I have established on a monthly payment schedule. It is our goal to provide health care through our practice that is accessible and affordable. (continued on the next page)

Returned checks are automatically forwarded to a collection agency for immediate collection and I will be charged a $25.00 returned check fee on all returned checks. If the returned check amount is not resolved, additional charges may be applied as per Utah law.

Some illnesses or injuries cannot be treated of fully diagnosed in a single visit, and may require follow- up appointments. Follow-up visits must be documented and a claim for services must be filed. Copays and deductibles will apply.

I understand that I need to schedule an appointment for each family member who I want to have seen or for whom I have questions. Any time Dr. Heras is asked to see a child (even if it is just to "peek in the child's ears"), this information will be documented in the patient's chart and a claim for service will be filed. Any co-payments or unpaid balances from these visits are my responsibility.

It is my responsibility to arrive to my scheduled appointment on time. If I am more than 20 minutes late for my scheduled appointment, I may be asked to reschedule. I agree to give 24 hours cancellation notice of any prescheduled appointment that I am unable to attend. I understand that I may be charged $25.00 if I fail to keep a confirmed or scheduled appointment.

I have read, understand and agree to the provisions of the financial policy. I further understand that Dr. Heras reserves the right to alter this policy at any time.

_____ _____
Responsible Party Signature **Date**

_____ _____
Patient Name **Date**

_____ _____
Witness **Date**

Acknowledgement of Receipt: Notice of Privacy Practices for Dr. Heidi Heras

I, (print name)_____, as the personal representative of my child, have received a copy of Dr. Heidi Heras' Notice of Privacy Practices. I understand that Dr. Heidi Heras will manage my/my child's health information according to the practices as outlined in the Notice.

_____ _____
Responsible Party **Date**

Acknowledgement of Receipt: Arbitration Agreement

I, (print name)_____, as the personal representative of myself/my child have received a copy of Dr. Heidi Heras' arbitration Agreement.

_____ _____
Responsible Party **Date**

_____ _____
Witness **Date**

_____ _____
Signature of patient or Guarantor of patient **Date**

_____ _____
Witness **Date**

For office use only:

__/__/__ __/__/__ __/__/__

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