Mountain West Pediatrics & Bedtime Kids Care
Jim J. Gould, MD, FAAP
2356 North 400 East, Suite 202, Tooele, Utah 84074
435.843.8380 Office / 435.843.8382 Fax

MOUNTAIN WEST PEDIATRICS FINANCIAL POLICY

- Insurance companies are not designed to pay the entire fee associated with an office visit. All co-payments, and non-covered services must be paid in full at the time of service by the person accompanying the patient regardless of health insurance coverage arrangements or court directives (in the case of estranged or divorced parents). A $10.00 charge may be added to your account for billing costs of the required co-payment that is not made at the time of service.

- Patients without insurance will be Self-Pay. All self-pay charges are due on the same day services are rendered. A fee schedule is available upon request.

- Our office will submit claims to your insurance company as a courtesy service to you. It is important and your responsibility to know what services **your** insurance plan covers; we take no responsibility to know what services **your** insurance plan provides. Services that we render based upon provider/responsibility party agreement that are not covered by your insurance plan are your financial responsibility. We emphasize, as your health care providers, that our relationship is with you, not your insurance company.

- If your insurance company requires laboratory specimens to be sent to a specific lab, it is your responsibility to know the participating lab(s). Locally we can send labs to LabCorp, Quest, or the lab at Mountain West Medical Center. Please make us aware when labs are ordered before leaving the office.

- I authorize payment of medical benefits directly to Jim J Gould, MD dba. Mountain West Pediatrics.

- I authorize the use of my signature on all insurance claim submissions.

- I understand that a finance charge of 1.5% per month (18%APR) of unpaid balances will be added to my account. If there is a delinquent balance (3 statements sent after insurance payment or 3 statements after a self-pay visit) the account may be sent to Express Recovery Collection Services. I agree to pay up to an additional 40% collection fee and all associated court costs/legal fees with or without suit. If I have opted out of receiving a final notice for delinquent accounts by text or email, see contact options below, I understand a letter via certified mail or priority mail will be
sent. In sending this letter, a fee of up to $6.00 will be added on top of the additional collection fee.

Contact Options:
We want to stay in touch with you regarding your account and its collection status regarding balances due. In order for us to contact you regarding all past due accounts and any collection status they may have, you authorize us to contact you by telephone by sending text messages or emails at any number or email you have listed. You acknowledge that such contact could result in charges to you by your telephone carrier. Methods of contact may include the use of pre-recorded/artificial voice messages and/or the use of an automatic telephone dialing system, as applicable. You acknowledge and agree that this authorization shall extend to any billing or collection company or companies which may be assigned.

No, I do not authorize this (initials) _____

FINANCIAL POLICY (CONTINUED)

- I understand a bounced check charge of $20.00 will be applied for all returned checks.

- I authorize Jim J. Gould, MD or any assistants to take my detailed medical history and to perform any necessary examination to confirm the condition for which I seek medical attention and to perform such procedures that are in their professional judgment necessary and or desirable for your child's well-being. Parents will be very involved in this decision-making process.

- I authorize the release of information necessary to process insurance claims and to request payment of benefits to be made for services rendered.

- **No show appointments**: We are in the business of taking great care of your children and their healthcare needs. A missed appointment is a missed opportunity for someone else's child that may need to be seen. I agree to give 24 hours' notice for any cancellation of appointments. A fee of $50.00 will be applied to your account for missed appointments without prior cancellation or appointments cancelled less than 4 hours in advance. If you have made an appointment for the same day and you do not show up for the appointment, a $50.00 fee will be applied to your account. **The no-show fees must be paid in full prior to any future appointments.**
  I understand that if I am more than 15 minutes late for the scheduled appointment for my child, I may be asked to reschedule.

- If you are experiencing a financial hardship, please discuss this with the billing office staff. We will gladly work with you to make payment arrangements. Our billing company, **Alta Billing,** can be reached at **435-215-7901**.

- If you are bringing your child in for a preventative visit and an acute issue is addressed, be advised that an acute issue may be billed to your insurance as a separate encounter, and you may incur additional charges that will be your responsibility. Preventative, sick visits and medication checks should be scheduled separately so that adequate time is spent on each visit.

- The providers and office staff will not be put in the middle of domestic issues or disagreements over the phone or in the office. Please make decisions regarding appointments, vaccinating and/or any office procedures PRIOR to visiting our practice. Either parent can schedule an appointment for their child, be present for the visit and/or obtain a copy of the visit summary. (Subject to medical records fee.) It is both parents' responsibility to communicate with each other about the patients' care, office visit dates and any other pertinent information relevant to the patient. It is not the responsibility of the provider to communicate visit information to each custodial parent separately. If there are written legal orders that need to be followed, please bring a copy to the clinic so that we may add it to the chart.

- Our providers **will not** call the non-attending parent following visits. Additionally, we will not call a parent to notify of an appointment scheduled, rescheduled or canceled by the other. The responsibility of the bill for minors is with the parents or legal guardian. It is our policy to collect payment at the time of service from the parent, guardian or caretaker who brings the child in for the appointment. We reserve the right to charge an administrative fee for copying records should the requests become excessive. Should the issues that come between parents become disruptive to our organization or there is non-compliance with this policy, we reserve the right to discharge the family from the practice.

By signing this form, I acknowledge that I fully understand and agree with the above policies and procedures.

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Parent or Legal Guardian (Print) Relationship to Patient

** The financial policy must be adjusted yearly based upon clinic/legal policy changes.
For ease, please include the names of all your children so this only has to be completed once.
Thank you for your cooperation!

NAME:	DATE OF BIRTH:
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_____	_____
_____	_____
_____	_____
_____	_____
_____	_____