BOZEMAN CREEK
family health

Patient Signature Renewal Form:

In compliance with HIPPA regulations, BCFH is required to have patient signatures on file once a year.

I, ________________________ attest that all demographic information is correct and current
(patient name)

to my knowledge. I have read the credit policy and agree with the terms. I have read the privacy policy and agree with the terms. I have provided BCFH with my current insurance information.

Signature of patient: ______________________________ **Date:** ____________

Relationship to Patient (If not patient): ______________________________

If changes have occurred in demographics please state as follows:

Name: ______________________________

Mailing Address: ______________________________

City: ____________________ State: ____________ Zip Code: ____________

Home #: ______________ Work #: ______________ Cell # : ______________

Current Insurance Company: ______________________________

Credit Policy

It is the concern of our entire staff that financial matters do not become a burden, nor stand in the way of your receiving the best, most timely medical attention. It is for this purpose that we have formulated the following Credit Policy:

1. If you have insurance coverage, we will gladly file your insurance claim for you. We do request payment of any co-payment or deductible at the time the services are rendered. If you do not have insurance coverage, we request that you pay for all services when rendered.

If you are separated or divorced, the parent bringing the child in for treatment is responsible for payment at the time of service. Whatever financial agreement exists between you and your spouse is strictly your agreement and not part of our credit policy.

2. We currently are member physicians with New West, Blue Cross/Blue Shield of Montana, Medicare and Medicaid of Montana. However, we remind you that your insurance policy is a contract between you and your insurance company and does not affect our credit policy.

This practice is committed to providing the best medical treatment possible for our patients and charges what is usual and customary for our area. **You are responsible for payment in full regardless of your insurance company's determination of usual and customary allowances.**

3. We recognize the need to set up payment arrangements for patients who require extensive treatment. Any accounts with a balance of over $200 or more are asked to see our business office personnel to set up a payment plan.

4. Should circumstances arise where your account still has a balance one year from the date of service we ask that you seek alternative financial options and pay your account in full. Accounts that become greater than 90 days delinquent, with no attempt by the responsible party to make arrangements for payment, will be turned over to an independent collection agency.

5. Accounts returned to us as "undeliverable", i.e., moved without forwarding address, etc., will be held for one month, and if no contact is made, will be turned over to an independent collection agency.

6. In the event that an account must be turned over to a collection agency, we will request that you and your family seek medical care from another physician in the community. The fact that your obligation for payment has not been fulfilled injures the mutual respect required between doctor and patient to ensure the highest quality of medical care, and we must, therefore, insist the relationship be terminated. You will also be held responsible for any fee(s) associated with turning your account to collections.

The biggest single misunderstanding and possible source of problems for you and for us occurs when there is no communication about your financial matters. Please feel free to discuss fees and financial arrangements with us at any time. We are more than happy to work with you so that there is never a time that your medical care causes a financial burden. We will do our best to ensure that we fulfill our part of this agreement with you, and trust that you will do the same.

Patient/Guardian Signature: ______________________________ Date: ____________

Print Patient Name: ______________________________