

**Fall Creek Skin & Health**  
**Patient Policies**

**Medical Insurance:** As a courtesy to our patients we will submit a claim for covered medical services to your insurance company. However, we cannot guarantee payment on your claims. Your health insurance is a contract between you and the insurance company. As a medical care provider our relationship is with you, not your insurance company

**Cash Pay Patient/Healthshare:** Payment is expected at time of service for all cash pay patients and patients who participate with a Healthshare. For those patients participating with a Healthshare, it is then your responsibility to contact your Healthshare for reimbursement on services rendered.

**Missed Appointments:** Missed appointments represent a cost to us and an inconvenience to patients who would have liked to be seen. Please notify us 24 hours in advance if you are not able to make a scheduled appointment. If a patient fails to notify us to cancel their appointment twice (2 times), this will result in a \$25.00 charge to your account. This charge for no-shows is not billable to your insurance. If a "new patient" no-shows we reserve the right to have them become a cash-only patient when they reschedule.

**Payments/Copays:** Each patient is expected to pay their copay at the time of their visit. Patients with significant past due balances will not be allowed to schedule future appointments without payment.

**Insurance Card/Insurance Eligibility:** It is the responsibility of the patient to provide current and correct insurance information. Failure to provide current and complete insurance information may result in patient responsibility for balance.

**Contact Information:** It is a patient's responsibility to notify our office of address and phone number changes.

**Returned Checks:** Any returned check will be assessed a \$35.00 fee, in addition to the fees charged by your financial institution.

**Finance Charges/Collections:** After 60 days, unpaid accounts will be assessed a finance charge of 1.5% monthly (18% annum). I further understand and agree that in the event any unpaid balance is assigned to a third party for collection, that an additional collection fee of 35% of the unpaid balance will be added.

We understand that sometimes unforeseen financial problems may arise which may affect a patient's ability to make timely payments on your account. If such problems arise, it is your responsibility to contact us promptly for assistance in making arrangements.

Please contact our billing manager, Chelsea at **208-403-1178** with any questions you may have.

**I have read & understand the above patient policies & agree to abide by these terms & conditions.**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Print Name** \_\_\_\_\_