

Eagle Creek Family Medicine

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1281 E. Iron Eagle Drive
Eagle, ID 83616

Patient Name: _____ Date of Birth: _____

INSURANCE BILLING POLICY

Our policy is payment at the time of service unless other arrangements have been made in advance. Your insurance policy is a contract between you and your carrier. However, for your convenience, we will submit your claim to your primary insurance company. If the insurance company forwards payment to our office, you will be reimbursed for overpayment.

MEDICARE AUTHORIZATION

This office participates with Medicare, therefore we bill Medicare directly. Medicare pays what they call "usual and customary" fees. That is, they only pay a portion of our fee depending on available funds and their own fee schedule. The balance between a Medicare payment and our bill is the patient's responsibility.

I authorize the holder of my medical information to release to the Health Care Financing Administration, and its agents, any information needed to determine these benefits.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize Eagle Creek Family Medicine to release any information needed to my insurance carrier to determine benefits payable for related services. I hereby assign to Eagle Creek Family Medicine all payments for medical services rendered to me and/or my dependents.

RETURNED CHECK POLICY

Our policy is payment at the time of service unless other arrangements have been made in advance. There will be a \$35.00 fee for all returned insufficient fund checks and payments.

X

Signature of Patient/Patient Representative

Date

HIPAA NOTICE OF PRIVACY PRACTICES

I have been read and have been offered a copy of the HIPAA Notice of Privacy Practices for Eagle Creek Family Medicine. My signature below is an acknowledgement that I have read and been offered a copy of this Notice of Privacy Practices.

X

Signature of Patient/Patient Representative

Date