O L Y M P U S C L I N I C

4624 HOLLADAY BOULEVARD SLC, UT 84117 PHONE (801) 277-2682

FINANCIAL POLICY AND AGREEMENT

Thank you for choosing Olympus Clinic for your health care provider. We are committed to excellent patient care and we are always working to improve the quality of treatment and service our patients receive. The following is an explanation of our financial policy, which you must read and sign prior to any medical evaluation or treatment.

1. Each patient is responsible for his/her own bill. We accept cash, checks, MasterCard, Visa, Discover, and American Express cards.
2. Payment of all insurance company co-pays are required at the time medical services are rendered. If you are unable to pay for your services, we will be happy to reschedule your appointment.
3. Patients who have no insurance are offered two options:
   - You may pay a deposit ($80 for new patients and $60 for existing patients) and the rest of the bill will be mailed to you and due in full within in 45 days.
   - You may pay for the visit in full the day of your appointment with a 20% discount. Because we will not know the total of your bill until after your appointment has ended, we do require that either your license or a credit card be held with your chart at the front desk.
4. Insurance is filed as a courtesy; however, ultimate responsibility of payment lies with the patient. It is our policy to have patients provide their current insurance card at each visit. In order to facilitate claim processing, you must provide all insurance policy information and changes to our office. Your bill is your responsibility whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim.
5. If your insurance company has not paid your claim, our billing office will notify you. **You will need to contact your insurance company to determine why payment has not been made.**
6. A $32 fee will be charged on all returned checks.
7. In the event that full payment for charges incurred for my medical care is not made, I agree to pay the outstanding balance.
8. If my account goes to collections, all costs of collection, including 30% Collection Agency Commission, reasonable attorney fees, court costs, and interest at the rate of 21% per annum will be my responsibility.
9. There will be a fee charged for no show appointments. Cancellations must be made 24 hours in advance.

Authorization to Release Information

I hereby authorize the physicians of Olympus Clinic to release all information concerning my medical treatment to my insurance carriers or referring physicians. Your signature also constitutes authorization and direct assignment of payment to Olympus Clinic. I authorize Olympus Clinic to download my medical history and insurance benefits.

Patient Name (Please Print)	Date
Signature of Patient or Responsible Party	Relationship to Patient