Daniel B. Jinich, M.D., P.C.

Patient Financial Policy

We find that communication with our patients regarding our financial policy assists us in providing the best of service to you. If you have medical insurance, we will offer our assistance in helping you to receive your maximum benefits. In order to do that, we need your help and understanding.

As medical providers, our relationship is with you, not your insurance company. All charges are your responsibility. You will be requested to pay your co-payment at the time of the service. In some cases, we may be able to determine your coinsurance and deductible. In that case, coinsurance and deductibles are due at the time of service.

If you have insurance with which we participate, we will bill your insurance company for you. If you fail to provide the required insurance information needed to file a claim on your behalf, you will be responsible for your balance. We will require detailed information and a copy of your insurance card to be able to provide this service. Many insurance companies require referral or preauthorization for medical services. A copy of your card will help us to obtain these necessary approvals from your insurance company. **Obtaining authorization is not a guarantee of payment by your insurance company.**

Charges for medical services are due and payable at the time of service. The Billing Department is available if other financial arrangements are required. We do accept Visa and MasterCard. Accounts unpaid 90 days past the date of service are considered delinquent and are subject to collection proceedings. All checks returned for insufficient funds are assessed a fee of $40.00.

If you have any questions regarding this financial policy, please contact our Billing Department at 221-9991.

If your account is self-pay (no insurance) payment is due at time of service.

Release of Records

I authorize Daniel B. Jinich, M.D., P.C. to furnish medical information to any or all of the following: referrals to physicians involved in my treatment either directly to or through Colorado Regional Health Information Organization (electronic clearinghouse of medical information), Medicare, my insurance carrier, or my employer (for work-related injuries), medication history for e-Prescribing (electronically prescribing medications with your pharmacy), State of Colorado Immunization Registry (required by Colorado law that children administered vaccines be in the registry). Release of these records may include re-disclosures from other physicians or medical providers. I authorize Daniel B. Jinich, M.D., P.C. to follow up on claim issues and appeals on my behalf. This may include disclosing personal medical information.

HIPAA Privacy Practice Notice

I acknowledge receiving a copy of the HIPAA Privacy Practice Notice.

My health information may be discussed with my spouse or significant other, family members or friends that are listed below:

_____

_____

Health information may be left on my home answering machine/voicemail (circle one): **YES** **NO**

Consent To Treatment

I request and consent to routine and emergency medical care for the patient (and the patient's newborn child in maternity cases) including all routine examinations, test, vaccinations, and other procedures. I acknowledge that no guarantees have been made as to the results of such medical care. I understand a patient has the right to refuse treatment and that my signature below is not a consent to any special medical procedure.

ACKNOWLEDGEMENT: I have read and understand the above form in its entirety. I have had a full opportunity to ask questions concerning this form.

PRINT Patient Name: _____ DOB: _____

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SIGNATURE of Patient/Parent/Guardian **Date**