INTERMOUNTAIN
HEART CENTER

Patient Service Agreement

Consent for Services

I, ________________________________, hereby consent to examination and treatment by Intermountain Heart Center physicians, medical staff, and employees including diagnostic and/or therapeutic procedures ordered by the physician.

Financial Responsibility and Assignment of Benefits

It is to our mutual benefit that our patients understand our Payment Policy. We make every effort to keep the cost of your medical care to a minimum. If your insurance company is one with which we participate, we will bill your insurance company as a courtesy to our patients. Ultimately, responsibility for payment lies with the patient.

I, the undersigned, agree that all benefits from insurance companies or any other third party payer will be paid directly to Intermountain Heart Center, PC for services rendered by the health care providers employed by Intermountain Heart Center, PC.

I certify that the information reported with regard to insurance coverage is correct and further authorize the release for any necessary information, including medical information, for this or any related claim, to the insurance carrier. In making this assignment, I understand and agree that I am financially responsible for changes not paid under this insurance policy.

I guarantee payment of all said charges incurred in accordance with the policy of payment of bills. **I agree to pay all co-payments at the time of service, all deductibles, co-insurance and all non-covered services regardless of the amount paid by my insurance or any other third party payer.** A fee of $10.00 will be added for each date of service when co-payments are not paid at the time of service. I further agree to pay interest fees at the rate of 1 ½% per month (18% annually) for any outstanding balance. Interest charges will begin to accrue 45 days after services rendered. In the event the account must be placed with an attorney or collection agency to obtain payment, I agree to pay all attorney fees, court costs, filing fees, including charges or commissions that may be assessed by any collection agency retained to pursue collection on outstanding balances, with or without suit. The cost of collection is 25% of the total balance owed.

I agree to pay a return processing fee of $25.00, or the highest amount allowed by law, for any check, or other payment method, that is returned unpaid to Intermountain Heart Center, PC. Any credit on an account of $10.00 or less will not be refunded unless requested by the patient.

Identification

We will require you to bring your driver's license or state-issued identification card along with your insurance card to our office at each visit.

Cancellation Policy

Our office requests that if an appointment needs to be cancelled that we receive a notice no later than 4 hours prior to the appointment. We reserve the right to charge $25.00 for a "no show" appointment, to be collected on or before your next appointment.

Release of Information and Privacy Notice

The law requires Intermountain Heart Center, PC to make and keep records of the patient's medical treatment. Intermountain Heart Center safeguards those records and it uses and discloses such records and any information they contain only in accordance with Utah State and Federal privacy laws. Such uses and disclosures are described in detail in the HIPAA Notice of Privacy Practices. The HIPAA Notice of Privacy Practices is available for the patient to review at anytime.

Acknowledgement

I acknowledge I have received or been offered the HIPAA Notice of Privacy Practices by Intermountain Heart Center, PC. As the patient, or the representative of the patient, I have read the above information and give consent and agree to the terms. All of my questions regarding privacy and this agreement have been answered and a copy has been offered.

I have read, understand, and agree to abide by all of the above referenced policies and information.

Signature:____

Printed Name:____

Date:____