Dynamic Healthcare Team

2855 Dublin Boulevard, Colorado Springs, Colorado 80918
Telephone: (719) 265-6464 Fax: (719) 265-6750

Updated 11/2023

Acknowledgment of Receipt of Notice

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. If you would like a paper copy please ask the front office staff.

Would you like to receive a copy of any amended Notice of Privacy Practices? YES NO

Signed: _____ Date: _____

Printed Name: _____

Confidential Channel of Communication Request

I, _____ **DO** authorize the following individual(s) a confidential channel for any communications of information related to my personal health, treatment or payment for treatment.

Name	Relationship	Phone

I, _____ **DO NOT** authorize the following individual(s) a confidential channel for any communications of information related to my personal health, treatment or payment for treatment.

Name	Relationship	Phone

Financial Policy

Thank you for choosing us as your health care provider. Our commitment is to provide quality treatment for you. Please understand that payment of your bill is considered a part of your partnership and treatment. This is a statement of our financial policy. We require you read and sign this prior to treatment. All patients must complete our information and insurance forms before being seen at this office. Full payment for services and / or coinsurance payment or do it time of service. We accept cash, checks, Visa, MasterCard and discover.

Regarding Insurance

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We may accept assignment of insurance benefits if your insurance is accepted at this office. Any remaining balance is your responsibility. In order for us to bill your insurance company you must give us current and correct Insurance information. Your insurance policy is a contract between you and your insurance company. Please be aware of that some, and perhaps all, of the services provided maybe non-covered services and are considered reasonable and necessary under your medical insurance policy. Regarding insurance plans in which we are a participating provider, all co-pays are due prior to treatment. In the event that you're insurance coverage changes to a plan for which we are not participating providers refer to the above paragraph.

Collections and Billing

1. Our billing cycle occurs at the end of every month.
2. A $5 rebuilding fee will be added to any account if it is necessary to submit a bill to the patient, this is simply to cover our costs (postage, employee time, etc.)
3. Unfortunately at times in the past some patients have not been responsible about paying their doctor bills. If an account has been billed for 3 months without payment or sufficient cooperation on the part of the patient, the account is turned over to collections.
4. Any overdue amount that is turned over to collections will be charged an additional 33.3% to cover collections cost.
5. We will not intentionally turn any account over to collections if the patient is cooperating and making an effort to keep their account current.
6. If you think there has been an error on your account you must notify us within 30 days and we will make effort to correct the situation.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is a usual and customary for our area you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients

The parent or guardian of any minor seen in the office is responsible for full payment. For unaccompanied minors, the non-emergency treatment cannot be delivered unless consent for treatment has been given and charges have been pre-authorized.

Missed Appointments

Please help us to serve you by keeping scheduled appointments. If you will be unable to keep your scheduled appointment you must cancel it on the preceding day. If an appointment is missed and not canceled by the preceding day, our policy is to charge $35 for same-day cancellations and no show appointments.

_____

Signature of Patient or Guardian

_____ _____

Name of Patient Date