Sawtooth Mountain Clinic, Inc. (SMC)
Credit Policy

It is the intent of the Sawtooth Mountain Clinic, Inc. that the patient is always responsible for full payment of services rendered. **Insurance co-pays are expected at the time of service.**

All charges are expected to be paid in full at the time of service, for those covered by insurance companies for which SMC is not a contracted provider, unless other arrangements have been made with the Patients Account Representative.

The staff reminds you that HEALTH INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. Clinic personnel will cooperate with you in every way to expedite your claims, but it is YOUR ultimate responsibility to see YOUR claims are honored. The Clinic looks to you, the patient, for payment of its fees.

Patients whose accounts exceed thirty (30) days without any arrangement or communication will be placed on a pay-as-you-go basis until the account is paid in full. Patients whose accounts are over ninety (90) days may have their account turned over to a collection agency.

Patients will be expected to pay for services as rendered unless other arrangements are made with the Credit Manager. Payment may be made by cash, check or credit card. If Sawtooth Mountain Clinic is provided with current complete insurance information, these claims will be filed directly to your insurance company for you.

The credit policies of the Clinic enable you to receive medical care and services when you need help and to make arrangements for payment. The essence of our agreement with you is COMMUNICATION. Please keep in contact with us regarding your account.

Reminder: If you have filed an insurance claim with your insurance company, you are still subject to collection on past due balances. Your health insurance is a contract between YOU and YOUR insurance company ONLY.

Medicare and/or other Third Party Assignment

I hereby direct payment of all medical, laboratory and x-ray, and/or surgical benefits, if any otherwise payable to me for services rendered by the SAWTOOTH MOUNTAIN CLINIC, INC. to SAWTOOTH MOUNTAIN CLINIC, INC., until revoked in writing. I understand I am responsible for charges not covered by my medical insurance. For services that Medicare will not cover, those charges will be the patient's responsibility.

I also authorize SAWTOOTH MOUNTAIN CLINIC, INC., to release information acquired in the course of my examination and treatment to my insurance provider, and also to provide medical records to other health care professionals for my continuing care. I permit photographic or facsimile reproduction of this authorization in place of the original.

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Date Signature of Patient

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I have received the Notice of Privacy Practices