ANDREA DEMPSEY M.D.
Board Certified Internal Medicine
"Wellness for Life"
7170 Smoke Ranch Rd Suite 110 Las Vegas, NV 89128
Phone (702) 463-3333 **Fax** (702) 541-6081

Patient Name:_____ DOB:_____ Date:_____

Thank you for choosing us as your healthcare provider. The following is our Financial Policy. If you have any questions or concern about our payment policies, please do not hesitate to ask for our Billing Department.

You must understand the following:

1. Your insurance policy is a contract between you, your employer, and the insurance company. Our relationship is with you, not your insurance company.
2. You agree to provide your correct name, social security number, address, phone number, email address, driver's license and picture identification at the time of registration or as requested by the practice at any time.
3. All services are provided to you with the understanding that you are responsible for their cost regardless of your insurance coverage. If you would like to know the cost of a service, please inquire with the staff prior to treatment. Please be aware that not all services are a covered benefit in all insurance policies. You are responsible for knowing, per your insurance plan on what services are or are not covered. **Fees for these services, along with any unpaid deductible and co-payment are due prior to the time of treatment**. You are responsible for these amounts. By your signature below, you accept financial responsibility for all services rendered to you.
4. You are responsible for knowing your insurance benefits. Does your insurance require a referral? What facilities participate in your plan? If we can be of assistance, please let us know. We are sure we can answer most questions regarding your insurance.
5. We will send you a statement monthly to keep you informed on the status of your account until the account is paid in full or placed in collection.
6. We will bill the insurance information you provided **to us as a courtesy,** but you are still ultimately responsible for payment of any services you receive. We will also follow up on your claim. We will be checking with your carrier once verbally and once in writing. In the event that your insurer sends you the payment for a claim from our office to you directly, you agree to endorse the payment to our practice in fulfillment of any amounts due within 10 days of postmark. **Slow insurance response:** If, however, your insurance does not respond to us within 60 days of claim submission, the amount will become your responsibility and you will have to follow up with your carrier for payment of the claim.
7. If your medical claim has not been paid by your insurance company, and you have contacted them with no results, there is recourse for you. The Nevada Department of Business and Industry has established an insurance division to receive questions, complaints, and comments from the consumers in Nevada concerning healthcare plans. Their address is 555 E. Washington Ave., Las Vegas, NV 89101 and phone number is: (702) 486-4000.
8. If you are a Medicare beneficiary by Federal Law we are required to collect 20% of the "Medicare Assignment" portion which the Federal Government does not pay. Medicare will only pay 80% of the assigned amount after your deductible has been paid. Again, if you have a financial problem or questions, please ask for our Billing Department.
9. Failure to cancel or reschedule an appointment without 24 hours notice will result in a $40.00 late fee. We require a minimum of 24 hours (or Friday before a Monday appointment) notice of cancelation as a courtesy to other patients seeking medical services. A fee of $40 dollars will be charged for non-cancelled and missed appointments. A pattern of missed or non canceled visits may result in discharge from the practice.
10. Emergencies: Our providers will make every effort to receive your calls and respond to an urgent situation. If you do not receive an immediate response then you will call 911, receive paramedic intervention, and seek the nearest emergency room.
11. Prescription Refills: It is our policy that you should be responsible to know when your medications must be refilled at least a week before you run out of medications. Medications are refilled only at the patient visit or when requested through your pharmacy, these are the preferred ways. We cannot take walk in, after hours or last minute phone call requests.
12. Telephone Encounters and Sick Patients: Our practitioners do not treat new patients or new illnesses over the phone. The physician or PA may elect to treat an existing patient seeking continuing care for an existing condition over the phone. Such consultations because they are not face to face are not covered by insurance and will result in a charge of $35. Payment for these services is your responsibility.
13. Form Fees: Our practice charges additional fees for paperwork outside of the completion of the medical records. The following fees apply and are subject to change without notice: 1) duplicate prescriptions, orders or referrals $25; 2) single page forms-$25; 3) multi page forms-$50 4) FMLA-$50.

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14. Medical Records: The medical record is the property of the practice; however, copies of your pertinent medical information are available upon request. The practice charges a fee for copying the record at 60 cents a page.
15. Accident and Workman Comp: Although our office is happy to treat your medical conditions, if the cause is related to a motor vehicle accident or work related accident you will be required to pay full fees for the visit (according to the level of visit) and we will provide you a receipt to submit to your insurance.
16. Patient Discharge: The practice reserves the right to discharge a patient for any reason. Please note that discharges may result for failure to meet your obligations under this document. In addition, because of quality considerations, the practice may discharge you for failure to comply with treatment plans as outlined by your practitioner.

Please be aware that we do understand any temporary problems one may have at the time of the visit. We encourage you to make us aware of this prior to the treatment, so we can assist you in any way regarding your balance. **OUR MAIN CONCERN ARE OUR PATIENTS WELL BEING.**

PROPRIETOR GUARANTEE:
By signing this Agreement I/We acknowledge that I have personally guaranteed the debts and obligation incurred by the undersigned, and agree that I am personally obligated to perform all of the terms of, and make all payments to (your Practice) required by, the Agreement of which this Application is a part. I/We hereby consent to and authorize all services. I/We hereby agree to inform this office of any changes in my/our address, as it may occur. I/We authorize this office to release any necessary information to third parties, when requested and if we become delinquent and my account is assigned to your Collection Agency associate they are hereby given the right to report same accurately to all the Credit Bureaus.

AGREEMENT OF FINANCIAL RESPONSIBILITY

I/We agree to pay all collection expenses the Practice may incur in collection our delinquent balance, plus $45.00 returned check fee. Collection Fees will be 40% for Regular Collections and 50% for Legal Collections or Forwards, which may be as much as twice the original principal balance owing. Attorney's fees, court costs, filing fees will be the patient's responsibility from the date legal action is filed., Patient is responsible for all charges and commissions that may be assessed by any collection agency retained to pursue this matter. Patient further agrees to pay interest rate of 2 (two) percent per month, 24 (twenty-four) percent per year from the first date the account becomes delinquent.

Credit information will be used for permissible purposes only. Unauthorized access is a crime and may result in criminal prosecution. Patients are required to retain supporting documentation for each transaction

I/WE CERTIFY WE HAVE READ AND UNDERSTAND ALL THE INFORMATION PROVIDED.
I/WE CERTIFY THE INFORMATION PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY/OUR KNOWLEDGE.

SIGNATURE OF RESPONSIBLE PARTY	SOCIAL SECURITY NO.	DATE

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H.I.P.A.A. COMPLIANCE: Our Office, Staff and Associates are conversant with and abide by the Rules, Regulations and Statutes relevant to the protocols of law regarding the Federal Law governing the protection of Individual Consumer / Patient Privacy.

PRIVACY POLICY: We do not share "Non Public Information" with any "Third Parties or Entities" All information provided shall be kept confidential and we shall treat same as privileged. Past due debts will be reported to the National Credit Bureaus in accordance and compliance with all F.D.C.P.A. and F.C.R.A. Federal Statutes.