Canyon Medical Group – Financial Agreement & Policy Statement

Patient Full Name: _____ DOB: _____

Responsible Party (if different than patient): _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Email Address: _____

Policy Overview

At Canyon Medical Group, we are committed to delivering quality care while helping you understand your financial obligations. This policy outlines the terms and responsibilities related to payment for medical services.

Billing and Payment Terms

- You agree to pay for all services rendered to you (or your child or ward) at the time of service or within thirty (30) days of billing if credit has been extended. If unpaid after 30 days, a 10% monthly finance charge will accrue on the unpaid balance, before and after any legal judgment.
- A **$50 pre-pay deposit** is required from self-pay patients before the visit; same-day payment of the full balance is required to qualify for any prompt-pay discount. If not paid in full, discounts are forfeited.
- Disputes regarding billed amounts must be submitted in writing within a 30 day period of the visit.

Insurance and Reimbursement Responsibility

- While we assist in submitting claims to most insurance carriers, you are ultimately responsible for your bill. This includes deductibles, co-insurance, and any services not covered by your insurance.
- We will provide itemized statements for insurance reimbursement. To submit claims on your behalf, we require timely and complete insurance details, including policy numbers, employer information, and insurance contact data.
- If delays or disputes in insurance payments arise, note that we cannot become involved in prolonged insurance negotiations; these are your responsibility.

Collections and Legal Fees

- If your account is referred to a collection agency, you agree to pay all outstanding balances plus any applicable:
  - Court costs
  - Reasonable attorney fees
  - Collection agency fees (up to 40% of the outstanding balance)
  - Interest at 18% annually, assessed both before and after a judgment is entered.

Authorization and Consent

- I authorize Canyon Medical Group to release necessary medical information to process claims and to receive payment directly from my insurance.
- I consent to be contacted at home, on my cell phone, or at work — including via automated systems — to discuss matters related to this account or my care.
- I certify the information I have provided is accurate and agree to comply with the policies stated herein.

Acknowledgment of Responsibility

Note: The person signing below understands and accepts to the terms of this Financial Policy. I accept full financial responsibility for all charges incurred today, and in the future, including but not limited to services rendered, insurance non-payment, and associated fees.

Signature (Patient if 18 or over Responsible Party): _____

Date: _____ Relationship to patient _____

Effective 06/01/2025