Dr. Michael Shaw
140 E. 1000 S., Suite B2
Brigham City, UT 84302
435-515-3030

PATIENT FINANCIAL AGREEMENT

Patient's Name_____

I understand that my insurance or healthcare plan may not provide coverage for such items as deductibles, co-payments, non-covered services and that I am responsible for all services received.

I agree to pay $75.00 towards my high deductible plan at the time of service

I agree to pay $ 40.00 per no show, or any appointment canceled within 24 hours with the exception of illness and medical emergencies

I agree to pay my co-payment at the time of service.

I understand that as a Medicare Beneficiary I am responsible for my $100.00 deductible and the 20% co-insurance.

I understand that Medicare and my Secondary Insurance will be billed. I agree to bring in any insurance payment I receive for services rendered to me at Mountain Top Medical.

I understand that I owe 100% of my bill and that I am responsible. I agree to pay balance in full.

I have been advised that if my insurance coverage should terminate during care, I will be financially responsible for services rendered to me after that date.

Due to my current financial situation, I am able to pay $_____ per v/w/m as my obligation for services rendered. Approved by:

Office staff signature: _____ Date: _____

Patient's Signature _____ Date _____