Bradley M. Burton, M.D.
E. Evan Holmstead, M.D.
Mallory Driscoll, PA-C

MOUNTAIN VIEW
family medicine

2006 Birdie Thompson Drive
Pocatello, Idaho 83201
208-232-1132
208-232-1134 (fax)

Financial Policy

We are dedicated to providing you with the best possible care and service and want to make sure you understand our financial policy. To assist you, we have the following for your review. If you have any questions, please feel free to discuss them with our front office staff or billing department. Unless other arrangements have been made, we expect payment at the time of service. For your convenience, we accept personal checks, cash, Visa, Mastercard, Discover, American Express and all Debit Cards.

Your Insurance: We must emphasize that as medical care providers, our relationship is with you, not your insurance company. As a courtesy, we will file your insurance claim for you. If your insurance company does not respond or pay within a reasonable length of time (60 days), you will be responsible for the balance. In addition, your copay is due at time of service. _____
(INITIALS)

As a patient in our office, it is your responsibility to inform us of any changes on you account regarding your insurance or contact information.

Delinquent Accounts: If your account is more than 90 days past due or over $300.00, you are expected to either pay the account balance in full or meet with our billing department for other arrangements. Please be aware that we will review all delinquent accounts and may transfer unattended accounts to our collection agency, and you will be responsible for all associated fees. Once you have been sent to collections, you will be discharged as our patient. _____
(INITALS)

Returned Checks: All returned checks will be subject to an additional processing fee of $25.00. _____
(INITIALS)

Missed or Late Appointments: Should it be necessary to miss an appointment, please notify our office a minimum of 24 hours in advance. We understand that life can be unpredictable, but our physicians strive to keep a punctual schedule and we expect our patients to follow the same guidelines. If you are more than 15 minutes late for an appointment, you may be asked to reschedule your appointment. _____
(INITIALS)

Minors: For all services rendered to a minor, the accompanying adult will be responsible for the payment.

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(INITIALS)

Patient Conduct: Mountain View Family Medicine has the option to discharge any patient at any time with the consent of the physicians and office manager. Our clinic promotes a positive working environment and our patients do not have the right to participate in any action that may jeopardize or compromise the health and well being of our employees and other patients._____
(INITIALS)

I have read and fully understand the financial policy of Mountain View Family Medicine and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time as designated by the practice.

_____ _____
(Signature of Patient or Responsible Party) (Date)