WELCOME! Thank you for choosing us for your care. Our mission is to provide the highest quality care that is convenient and comprehensive to our patients. In effort to reduce confusion between our patients and the practice we have adopted the following policies for our office

Please read its entirety

- For Prescription Refills, please contact your pharmacy and have them send a refill request.
- We are required by law to collect your copays, deductibles, and co-insurance in a timely matter. Please assist us with this by having your payment ready at the time of service.
- No child Under the age of 18 may be left unattended anywhere in our facility.
- Please call us and let us know if you are unable to make it to your appointment at least 24 hours in advance. If you "No Show" for your appointment three times, we will discontinue care for you at our facility. In addition, if you do not show up for your appointment or if you do not cancel your scheduled appointment at least 24 hours prior to your scheduled time, you will be charged a fee of $35.00.
- We have a financial interest in the Ultrasound Scan services, the Neurostar, and the pulse 4 pulse cardiac testing offered at Advanced Specialty Care. You have the right to receive any of these services at another facility if you desire to do so. Please advise the staff if you elect another facility.

All account balances are due within 30 days of receiving a statement. Any Account with an outstanding balance after 90 days will be transferred to an outside collection agency. *Please note at the time your account is transferred your account will be charged 25% of the remaining balance and the collection agency may have additional fees if not promptly paid*. It is very important to keep us informed if you are on a payment arrangement and are going to miss a payment to avoid these additional fees. Also, if your account is transferred to an outside collection agency, we will no longer be able to see you until your account is paid in full. We will finance any acceptable payment arrangement that meets our policy criteria, with a finance charge of 1% per month if it takes you more than 12 months to pay it off.

Please also be aware that anytime there is a lab drawn or specimen taken from you (biopsy, blood, swabs, Pap smear, excision, etc...) it will be sent to an outside lab. You will receive a bill from that lab in addition to our charges. Please ask if you have any concerns regarding which lab will be used for you and/or lab charges.

Please do not hesitate to contact us if you have additional questions.

Patient Signature: ________________________________ Date:____________________________

Patient Name: ____________________ **Date of Birth:** ________________________

Dear Patient,

Payment is required at time of service.

Due to policy provisions in your contract with your insurance carrier we are obligated to collect all patient responsibility balances.

If your insurance policy has provisions such as deductibles, co-insurances, or co-payments please note that these are provisions that have been agreed between you and your carrier. We cannot legally discount fees after their submission on your behalf to your carrier.

If we are networked with your carrier, we have an additional contractual obligation to collect the balances as outlined by your carrier. Writing off patient responsibility balance could jeopardize our contract with your carrier. If a portion of your fees are applied to an annual out of pocket maximum, and we do not collect that fee, your out-of-pocket maximum has not been correctly calculated.

Additionally, for those Medicare patients that any have any medical services that are eligible under Medicare, we are legally obligated to collect the patient responsibility co-insurance, co-payments, or deductible under the terms of the anti-kickback laws.

We sincerely regret if any of these regulatory provisions cause you any inconvenience, but we must be bound by all provisions of insurance policy and federal law. If you have any issues or concerns with your insurance, we will be more than happy to assist in the resolution of those issues or concerns. Please feel free to contact us with any questions you may have or any assistance you may require to fully understand these provisions.

Thank you for your understanding in the matter.

How did you hear about us? ____________________________

Patient's Name: ___________________________ Date of Birth: _________________________

Email Address: ____

For questions regarding your bill from Advanced Specialty Care please call 208-468-9400.

For questions regarding your bill from Lab Corp please call 1-800-845-6167.

For questions regarding your bill from St. Luke's please call 208-381-2222 and ask for their billing department.

For questions regarding your bill from St. Alphonsus please call 208-367-2121 and ask to speak with their billing department.

I agree and give permission for Advanced Specialty Care to send my summary of services to the above-listed email address. I understand that I may reach out at any time with any questions or concerns. However, if I disagree with the summary of services, I agree to reach out within 7 business days.

__________________________________ ___________________________

Responsible Party Signature Date

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Relationship to Patient