 

Telluride Regional Medical Center Financial Policy

**Please read the following financial policy. Ask us any questions you may have, then sign and print your name at the bottom of the page. Include today’s date.**

# Co-pays: All copayments are due at the time of check-in. We accept cash, check, or credit cards.

# Insurance Claims: If you have presented us with insurance information that has an address within the United States and is not out of state Medicaid, we will submit the claim on your behalf. You will be responsible for any further communication with your insurance company and for any outstanding balance after the insurance company has processed the claim. It is your responsibility to know your insurance plan. If you are unsure if *TRMC* is contracted with your insurance company, call them to verify your coverage.

# Self-Pay: Self-pay accounts are patients without insurance, out of the country insurance plans or patients that are not able to present eligible insurance. Payment will be expected within 90 days of the statement date. If payment in full cannot be made, contact the Patient Billing Department at *888-862-6085* to discuss payment options and to answer any other questions you may have.

# Non-Payment: If your account is over 90 days past due and you have not contacted us to set up payment arrangements, your account will be referred to a collection agency. Should the account be referred to an attorney or collection agency for collection, you shall pay actual attorney’s fees and collection expenses.

# Assignment of Insurance Benefits: I hereby authorize any third party responsible for any portion of the patient’s covered medical services to make payment directly to *TRMC* and/or *Mountain Radiology* and/or *LabCorp* and/or *Myriad*, and/or *Ambry Genetics*, and/or *University of Utah Dept of Dermatology*. I acknowledge that this assignment of benefits is irrevocable and assigns to the medical providers all rights under my insurance policies. I further understand that I am financially responsible to *TRMC* and/or *Mountain Radiology* and/or *LabCorp* and/or *Myriad*, and/or *Ambry Genetics*, and/or *University of Utah Dept of Dermatology* for charges not covered by any insurance or third-party payor.

**Discounted Care:** By signing below, I acknowledge that I have received all required notices, advisements, and forms required to apply for the Financial Assistance program offered at *TRMC*. I understand that if the application is not completed or incorrectly filed within the set timeline, then I will be ineligible for this program and any potential discounts.

# Consent to Wireless Telephone Calls: By signing below, I consent to be contacted by regular mail, text, email or by telephone (including a cell phone number) regarding any matter related to the referenced account by the creditor, its successors or assigns. This consent includes any updated or additional contact information that I may provide and includes contact that employs auto dialer or unattended dialer technology and/or prerecorded messages.

# Motor Vehicle Accident and Workman’s Compensation: We will bill your motor vehicle insurance company or Worker’s Compensation Company. If the claim is denied, you will be responsible for payment in full.

Signature of Patient or Responsible Party Today’s Date

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Printed Name of Patient or Responsible Party