Diana R. Crumrine ND
1416 W Washington St
Boise, ID 83702
www.myfoothillsfamilymed.com

Payment Agreement

Dear New Patient,

Welcome to Foothills Family Medicine. We look forward to providing for your health care needs. We encourage your questions and participation in all aspects of your care. Please read and initial the following statements:

_______ Payment for all services and medicinary items are due at the time of the visit. We accept cash, checks, Visa or MasterCard. Returned checks will be subject to a $35.00 NSF fee.

_______ None of the doctors at Foothills Family Medicine are contracted providers with any insurance plan. If your plan has coverage for out of network naturopathic care we will provide you with the appropriate coding to submit your own claim.

_______ You will be charged a Missed Appointment fee of $50.00 for missed appointments or late cancellations (less than 24 hours notice).

_______ You will be billed for phone or e-mail correspondence based on complexity, ***except*** those regarding questions about prescribed treatments and conditions already being treated that require less than 10 minutes of attention.

_______ I understand that if I choose to do a phone or Skype consult that I will be billed based on complexity the same as a regular office visit for any new health issue. I understand that phone and Skype visits will <u>NOT</u> be covered by insurance reimbursements and I will be responsible for full payment.

_______ All medicinary items must be paid for at the time of purchase. Refunds or exchanges are given on unopened items in re-saleable conditions if returned within 30 days. No refunds or exchanges will be given for opened items after 30 days.

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Your health care provider may prescribe items which may be purchased at Foothills Family Medicine or elsewhere. Most insurance companies do not cover the pharmacy items that we prescribe and dispense and certain lab tests that we may order.

Usual and customary Evaluation and Management or other medically necessary services may be billable to my insurance. I understand that this requires my payment in full for all medicinary items and I will not attempt to bill my own insurance company for any of these services.

I have read and understand the above-stated policies of Foothills Family Medicine and will comply with them in all respects. If my insurance company requires release of my medical records, I hereby give my permission by signing this form.

______________________	______________________	__________
Printed Name of Patient	Signature of Patient	Date
______________________	______________________	__________
Printed Name of Parent/Guardian	Signature of Parent/Guardian	Date
______________________	______________________	__________
Printed Name of Provider	Signature of Provider	Date