M. Terry Jeppson, MD
Patient Information and Office Insurance Policy

PLEASE SHOW YOUR INSURANCE CARD TO THE RECEPTIONIST

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account. I agree to pay ALL re-billing, interest, financial and collection costs, and reasonable legal fees. I request that payment under the medical insurance program be made to the provider of medical services. I authorize the provider to release to my insurance carrier any information needed for those claims.

As a courtesy, we submit to your primary and secondary insurance companies as long as the information provided to us by you is correct. Please remember that professional services rendered are charged to the patient and not the insurance company. **This office DOES NOT accepts responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.** Health insurance is a contract between you and your insurance company and does not create a credit in this office. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges and secondary insurance etc; other than to supply factual information as necessary.

FULL payment is expected at the time services are rendered, unless other arrangements have been made in advance. Please check with our financial biller for arrangements.

FINANCIAL CHARGES:
If for some reason we allow you to have a balance, with us, at our discretion, there will be a financial charge per month for accounts aged over 60 days.

I understand if I have an unpaid balance to Dr Jeppson and do not make satisfactory payment arrangements,
my account may be placed with an external collection agency. I will be responsible for reimbursement of any
fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.
In order for Dr Jeppson's office or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that they are authorized to (i) contact me by telephone at the
telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to
me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email
address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or
use of an automatic dialing device, as applicable.

Medicare Beneficiary Signature on file form

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare claims. I permit a copy of this authorization to be used in place of the original and requested payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.
By signing this policy, you agree that you are ultimately responsible for the balance on
your account and agree to pay ALL fees.

_____ _____

Signature/Responsible Party Date

M. Terry Jeppson, MD
Patient Information and Office Insurance Policy

PATIENT NAME:_____ DATE OF BIRTH: _____

ADDRESS:_____ CITY: _____

STATE/ZIP CODE:_____ /_____ CELL PHONE: (____)_____

EMAIL: _____

EMPLOYMENT: _____ WORK PHONE: (____)_____

HUSBAND/PARENT: _____ DATE OF BIRTH:_____

ADDRESS:_____ CITY: _____

STATE/ZIP CODE:_____ /_____ CELL PHONE: (____)_____

EMERGENCY CONTACT #1: PHONE: (____)_____

EMERGENCY CONTACT #2: PHONE: (____)_____

MEDICAL ALLERGIES: _____

PREFERRED PHARMACY:_____

INSURANCE (GIVE COPY TO RECEPTIONIST)

Insurance Company:_____

Policy Holder: ID# _____Group #:_____

Authorization to Mail, Call, Text or Email

I certify that I understand and am responsible for the privacy risk of mail, phone calls, text or email. I hereby authorize a representative of this office to mail, call, text or email me with communications regarding my healthcare, including by not limited to appointment reminders, referral arrangements and test results. I understand that I have the right to rescind this authorization at any time by notifying this office to that effect in writing.

** I have received/reviewed a copy of Dr. Jeppson's privacy policy.

_____ _____

Signature Date