Weber-Morgan Health Department
477 23rd St.
Ogden, UT 84401

08/30/2023

Weber-Morgan Health Department (WMHD) promises to provide competent, timely and ethical medical billing practices/services. We will work with individuals and operate with a culture of equity, integrity, compassion, and patient focus.

PATIENT RESPONSIBILITY: I understand that I am financially responsible for all services rendered. WMHD bills insurance as a courtesy for some services, but does not have the ability to bill insurance for all service types. STI services, immigration, and non-covered immunization or travel services, are payable at the time of service.

<u>Insured Clients:</u>
I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and I may be responsible for any unpaid balance. Any balances left unpaid beyond ninety days after my initial statement date may be sent to a collection agency.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I understand that I am now the responsible party for the full balance.

I understand it is my responsibility to be aware of my insurance deductible, co-payment, co-insurance; out-of-network status; usual and customary limits; prior authorizations or referrals needed from a primary care physician (and I also must obtain authorization or referral in advance) or any other limitations on the benefits for the services I receive. I will be held financially liable for all such insurance requirements or limitations.

If I am a Medicare patient, I understand that I need to provide the office all insurance cards including my Medicare ID. If the office does not have the proper information for my secondary insurance, the secondary cannot, and will not be billed. It is my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

<u>Underinsured Clients:</u>
I understand state-funded vaccinations for underinsured children (aged 0-18) or adults are not available at WMHD. State funded vaccinations for the underinsured are available at Federally Qualified Health Centers.

If I have a Health Care Sharing Plan (HCSP), it is my responsibility to know whether it is recognized as an insurance plan or an HCSP. If uncertain, WMHD staff may be able to check if my HCSP is a recognized insurance by the Utah Insurance Department. If the HCSP is not deemed an insurance, state-funded vaccine can be provided (if available), and I will be charged routine vaccine administration fees at a sliding fee discount according to proof of my income and family size. If the HCSP is an insurance, I will be asked to pay out of pocket for the vaccine and administration fees, provided a detailed receipt, and am free to seek reimbursement on my own.

If for any reason I do not want WMHD to bill my insurance or HCSP, I can pay out of pocket, and receive a detailed receipt to seek reimbursement on my own. I understand I am not guaranteed full reimbursement, if any, from my insurance or HCSP for the services I am provided. I understand state-funded vaccines are not reimbursable.

<u>Uninsured Immunization Clients:</u>
I understand state-funded vaccinations are available at WMHD for: children (aged 0-18) who are uninsured; covered under Medicaid or Chip; or those with American Indian/Alaskan Native heritage, and also in limited supply for uninsured adults (19+). Administration fees for routine state-funded vaccines can be offered by WMHD at a sliding fee discount, if I provide proof of income and family size.

<u>My medical insurance status today is:</u>
☐ No Insurance ☐ Private Insurance ☐ Medicare ☐ Medicaid ☐ Underinsured or Health Care Sharing Plan

<u>If insured, I am electing to have WMHD handle the billing for my services in the following manner:</u>
☐ Bill my insurance. I will make payment at time of service for services not typically covered. Credits resulting from my overpayment, may be redistributed to unpaid balances on my account or refunded, after settlement.
☐ Do not bill my insurance. I choose to pay out of pocket and may or may not seek reimbursement on my own.

Signature: ____ Date: ______________________________