EHCW
EDUCATIONAL HEALTH CENTER OF WYOMING

Albany Community Health Clinic | (307) 766-3313
1174 N 22nd St. | Laramie, WY 82072

Wyoming Family Practice | (307) 234-6161
1522 E. A St. | Casper, WY 82601

UW Family Medicine | (307) 632-2434
820 E. 17th St. | Cheyenne, WY 82001

Patient Financial Agreement:

The information provided on the Patient Registration Form is true and correct to the best of my knowledge. I request WFP to provide me/my family with medical care. I accept responsibility to pay for this care according to the fees established. Furthermore, I authorize assignment of benefits for medical service to be paid to the Wyoming Family Practice. Also, I authorize WFP to bill my insurance by electronic filing through a billing agency and to release any medical information needed for processing claims. In the event an X-ray and/or Lab test(s) are performed during my visit, I authorize WFP to release patient information to the external agency for the purpose related to the processing and billing of the ordered film(s) and/or test(s). I agree that any telephone number provided by me may be used by the clinic staff and/or its representatives as a means to contact me regarding my medical care or business.

I understand that I will be expected to provide all required information for determining eligibility for sliding fee discounts within two weeks of my visit. If I do not provide adequate financial information, I understand that I will be expected to pay in full for services rendered. I understand that I will be required to update all financial information every twelve months to remain eligible for any sliding fee discounts and that I will update my financial information immediately if my financial situation changes.

I understand that all sliding fees, co-pays, deductibles, and co-insurances are my responsibility and that these charges are due and payable at the time of check-in on the date of service. I understand there could be additional fees after my provider appointment, and that those fees are my responsibility.

I understand that if I have health insurance, payment for services is ultimately my responsibility and that WFP bills my insurance company as a courtesy to me. I understand that I may receive separate billing from outside agencies such as laboratories, pathologists, and radiologists, and that these charges are my responsibility.

I understand that if I am unable to pay my bill in full that I must make payment arrangements with the billing staff prior to the balance reaching 90 days past due. If the balance reaches 90 days past due without a written payment plan it is subject to an immediate turn to collections without additional notice to me.

I understand that it is my responsibility to keep WFP informed of my current address and telephone number. If a monthly billing statement is returned to WFP as undeliverable or no forwarding address and WFP is unable to contact me by telephone, I understand that my account will be turned to collections.

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I understand that if I have written a non-sufficient fund check, I will be expected to pay that check and the $15 fee by cash or credit card only and that any further financial transactions will be by cash or credit card only until the NSF check and fee are paid.

WFP is a non-profit organization, however, we must charge fees in order to continue providing health care services to all patients in need. **I understand that WFP is not a "free clinic"**.

Authorization to Obtain Medication History

By signing, I hereby authorize University of Wyoming Family Medicine Residency Casper to obtain Medication History related to the patient, from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of Continued Treatment.

_____

Patient, Parent/Legal Guardian Signature **Date**

Photographic Image:

I give my permission for the University of Wyoming Family Medicine Residency Program to use my/my dependent's image in my/their electronic medical record chart. **YES** **NO**

Initial_____

I understand that if I select NO, I will be required to present a PHOTO ID at every visit.

In signing below, I certify that I have read and understand the above regarding the Financial Agreement, the Notice of Privacy Practice and the use of my/my dependents photographic image.

I also certify that I have been offered the Registration Information Packet including the following documents:

- Patients' Rights and Responsibilities
- WFP Rights and Responsibilities
- Financial Responsibility Statement
- Appointment Policy

_____

Printed Patient Name Date

_____

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Patient Signature Date

Parent/Legal Guardian/Legally Authorized Representative Relationship Date