UCCS HealthCircle
Primary Care Clinic and Peak Nutrition Clinic
4863 North Nevada Ave. Suite 250
Colorado Springs, CO 80918
(t) 719-255-8001
(f) 719-255-8044

Patient Financial & Information Release:

- I understand that I am responsible for obtaining a referral or proper authorization with assistance from the UCCS HealthCircle Primary Care and Peak Nutrition Clinic staff from my insurance company for any procedures.
- I understand that I am responsible for knowing the benefits of the specific insurance plan(s) I have purchased, and that the UCCS HealthCircle Primary Care and Peak Nutrition Clinics are not responsible for interpreting these benefits. It is my responsibility to know which hospital and/or lab my insurance will reimburse for services. Specimens such as tissue biopsy samples, blood samples or urine will be sent to an outside lab contracted through my insurance company, in which case an outside charge may be associated with these services.
- I agree that if the insurance company denies benefits for any reason or if I have no insurance coverage, I will be responsible for the full amount of the service rendered. Patients are required to pay at the time the service is delivered if the service is not covered by insurance or if the patient has no insurance coverage.
- I understand that insurance co-payments are due on the date of service.
- I understand and agree to pay a $30.00 fee for any returned checks.
- I understand and agree to pay a $30.00 No-Show fee if I miss an appointment without notifying the UCCS HealthCircle Primary Care or Peak Nutrition Clinic. If I No-Show twice as an established patient I may be dismissed from the practice.
- I request that payment of authorized insurance/Medicare/Medicaid benefits be made to UCCS HEALTHCIRCLE PRIMARY CARE CLINIC (FEIN 84-6000555) or UCCS HEALTHCIRCLE PEAK NUTRITION CLINIC (FEIN 84-6000555) for any services rendered. If these payments are not sent to UCCS HCPCC or UCCS HCPNC, and sent directly to me, I agree to forward all insurance payments as soon as possible to UCCS HCPCC or UCCS HCPNC.
- In the event that my account becomes past due or is turned over to a collection agency for non-payment, I agree to pay all reasonable attorney's fees and costs of collection and understand that I will no longer be able to receive care at this office.
- I authorize any medical information about me to be released to my insurance carrier, its agents, and third party billing companies as needed to process and pay my claims or those of my dependents.
- I acknowledge that I can obtain a copy of the UCCS HealthCircle Primary Care Clinic and Peak Nutrition Clinic Notice of Privacy Practices at the front desk.
- In the event that I pay for my visit with a credit card and am overcharged and due a refund, the UCCS HealthCircle Primary Care Clinic or Peak Nutrition Clinic will refund the amount owed within 30 days of notification.

Patient Name: _____

Patient Signature: _____ Date: _____