

**Cheyenne Medical Specialists, P.C.**  
**5050 Powderhouse Rd.**  
**Cheyenne, WY 82009**  
**307-634-1311**

**INSURANCE AND FINANCIAL POLICIES**

**Thank you for choosing Cheyenne Medical Specialists, P.C. for your health care. If you have medical insurance that covers our services, we are happy to assist you in submitting your insurance claims. If CMS does not participate in your insurance plan, full payment is due on the date of service. We will bill your insurance. Co-pay, co-insurance, and deductibles are your responsibility and are due at the time of service.**

You are responsible for checking with your insurance plan regarding any co-payment, deductible or co-insurance that might be owed at the time of service. If you have questions about your coverage, speak to your employer or contact your insurer directly. Please bring your health insurance card and a photo ID with you at each visit and be prepared to pay your co-pay at check in. You will be asked to pay your deductible and co-insurance at check out.

**BY SIGNING THIS AGREEMENT YOU AGREE TO PAY YOUR CO-PAY, CO-INSURANCE, DEDUCTIBLE AND ANY FEES THAT YOUR INSURANCE COMPANY DOES NOT COVER, AT THE TIME OF SERVICE. IF YOU ARE NOT PREPARED TO PAY YOUR APPOINTMENT MAY BE RESCHEDULED.**

**Cancellation/Missed Appointments:**

As a courtesy to other patients requiring services, we request that you provide notice of cancellation 24 hours in advance of your appointment. **New patients, consults, and procedure appointments that are not cancelled within 24-hour notice will be charged a fee of \$50.00.**

**Method of Payment:**

**CMS accepts cash, checks, debit, Visa, Master Card, and Discover.**

**Authorizations:**

**I have read the above information and agree, regardless of my insurance, to be responsible for the balance of my account. I agree to pay for all services rendered not covered by my insurance and to notify this office should there be any change to my insurance coverage.**

**PATIENT OR AUTHORIZED PERSON'S SIGNATURE: \_\_\_\_\_**

**DATE: \_\_\_\_\_**

**Patient Name: \_\_\_\_\_**

**(Print)**

**I also agree to pay my balance in full within 60 days. If my balance is not paid within 60 days by my insurance or myself, I authorize the balance to be paid on my credit card as follows:**

**Card Type: \_\_\_\_\_ Card Number: \_\_\_\_\_**

**Exp.Date: \_\_\_\_\_ Security Code: \_\_\_\_\_**

**Card Holders Name: \_\_\_\_\_**

**SIGNATURE: \_\_\_\_\_**