North Canyon
MEDICAL CENTER

North Canyon Family Medicine Clinic

Medication Assisted Treatment Program Financial Agreement

Patient Printed Name: _____**Patient DOB**: _____

Please review the financial agreement for MAT Treatment Program/ North Canyon Family Medicine. By signing this letter, you are agreeing to all the terms in it:

1. I agree to pay my treatment fees prior to all of my appointments with North Canyon Family Medicine. First initial visit is $270.00 plus a baseline UA $45.00 totaling $315.00; all follow up visits once established is $125.00 per visit. Drug screenings at NCMC are an estimated $45.00; If a UA is positive it will be sent out for confirmation this will be an additional estimated cost of $155.00, you may be responsible for this additional cost, insurance may not cover this service rendered.

   Please Note: *Medicaid patients, you will be responsible for an out of pocket cost for your Suboxone prescriptions at the pharmacy for the first week of treatment. Medicaid will need a prior authorization approval for the medication. This cannot be done until after the initial appointment. It can take 3-7 business days to process authorization.*

2. I agree to make all of my payments in **cash or by credit card only**. Checks will not be accepted.

3. I agree that if my account were to become and/or is presently **60 days past due**, it may be grounds for my discharge from the program.

4. ***I agree to keep all my accounts with all facilities involved in my Treatment Program up to date and paid in full; maintaining a zero balance. Certain Insurance may cover your services, but until it is processed, you are responsible for all fees and/or copays tendered. Your account will be refunded accordingly if insurance processes your claim.***

By signing this agreement, I am certifying that all my billing information is correct to include my address, phone number and emergency contact(s). I will provide a copy of my insurance card and driver's license. I have read and agree to the terms above.

I,_____, as a client in the North Canyon Family Medicine MAT Treatment Program agree to abide by the terms and conditions set forth in this Agreement of Financial Compensation with North Canyon Family Medicine .

Patient Signature: _____ Date: _____

NCMC Staff Witness Signature: _____ Date: _____