New West PHYSICIANS

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Diabetes and Nutrition Center Financial Policy

Notice of Financial Responsibilities

We will bill your insurance company for diabetes classes and individual appointments (also called diabetes self-management education/training and medical nutrition therapy, Diabetes Self-Management or Medical Nutrition Therapy). Some insurance plans do not cover these services.

If Diabetes Self-Management or Medical Nutrition Therapy are not covered benefits, payment will be the patient's responsibility. In that case, we will offer a 20% discount for services. If the desired service is a covered benefit applied to a deductible, no further discount will be applied.

We will not contact your insurance company to check for coverage. You may contact us if you need specific information for your insurance company.

If you do not have insurance, we apply a 20% discount when bill is paid in full at the time of service.

Out of Pocket Services

Please note some services are out of pocket-please ask for details

Co-Pay Policy

Diabetes Self-Management and Medical Nutrition Therapy may or may not require a co-payment by your insurance company. If they require a co-payment, you will receive a bill from New West Physicians.

Office visits require the usual co-pay listed on your insurance card for primary care.

Late Cancellation and No-Show Policy

We require at least 24 hours' notice for all cancelled appointments. **Appointments cancelled less than 24 hours prior to the scheduled time will be charged a $25.00 late cancellation fee, with exception to emergencies.**

Missed appointments without cancelation will be charged a $75.00 no-show fee.

Multiple missed or late canceled appointments may result in requesting a patient withhold rescheduling until their schedule permits time.

Notice of Privacy Practices

New West Diabetes and Nutrition Center adheres to all of the privacy practices of New West Physicians and the Health Insurance Portability and Accountability Act (HIPAA) affective April 14, 2003.

By signing this document, I acknowledge that I have read this document in full and understand and agree to the terms stated above.

Signature-Patient/ Responsible Party _____ Date _____

Print patient name _____ Date of Birth _____

New West Physicians Diabetes and Nutrition Center

1697 Cole Blvd Suite 125 Golden, Colorado 80401 | Phone: (303) 716-8039 | Fax: (303) 202-3895

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