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PATIENT FINANCIAL POLICY

The purpose of this document is to inform our patients about ______________________ Financial Policy. If you have questions about the policy, please ask to speak with a member of our Customer Service Team. We are dedicated to providing the best possible care and services to you and regard your understanding of our financial policy as an element of your care and treatment.

1. Payment for all services provided by our practice is due in full at the time services are rendered. Exclusions to this policy are those patients who are a member of a health care organization that we have a participating agreement with, such as Medicare, Blue Cross Blue Shield and others. We will bill your primary insurance plans for which we have an agreement and will only require you to pay the authorized co-payment, deductible or non-covered services at the time of service.

2. Whenever you are having a procedure or surgery performed in the hospital, it is important to check if the facility also participates with your insurance company. It is the patient's responsibility to make this determination.

3. If you are a member of a health care organization that ________________________ does not have a participation agreement with, we will prepare and submit a claim for you. This means your insurer will send the payment directly to you and the charges for your care are due at the time service was rendered.

4. There is a $25.00 no show or late cancellation charge for office patients and a $50.00 charge for procedure patients. In order to avoid such charges, it is important that you call a member of our scheduling staff to cancel your appointment with a minimum of I business day prior to your appointment. This courtesy allows other patients who are waiting for an appointment to use this time slot.

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5, Medicare patients are responsible for their co-payments and any items deemed Medically Unnecessary by Medicare. In the event your health plan determines services to be "not covered" you will be responsible for the complete charge.

6. If you are unable to pay for the visit at the time of service, please call our office prior to the appointment to arrange a payment plan.

7. Patients will receive a monthly statement itemizing the services rendered and any unpaid patient balances. We may add a finance charge to any outstanding patient balance every month billed.

8. For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

9. ______________________________ accepts cash, personal checks, money orders, traveler checks, MasterCard, Visa, and Discover.

10. A *$25.00* fee will be assessed to the account for every check returned to ____________________________ for insufficient funds.

11. Refunds will be issued to patient on a monthly basis. Refunds will be issued in the form of a check to those accounts paid with cash or check (check must have cleared bank first). Any payments made by credit card will be refunded directly back to the patient's credit card.

12. ____________________________ reserves the right to turn any patient over to collections if it is deemed that the account has been in default of the payment obligations or compliance of this policy. It is understood and agreed that ____________________________ shall recover all costs and expenses incurred in the collection of any such delinquent amounts.

13. There will be a S 10.00 charge for the completion of every form we are asked to complete by patient, insurance companies, etc.

I, _____________________________________, understand and agree to the provisions in this Patient Financial Policy:

____ *(Sign Here)*

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