

**Financial & Office Policies**

Initial \_\_\_\_ **INSURANCE PLANS:** I understand that it is my responsibility to confirm with my insurance company that the physician is currently under contract with my plan or be willing to be seen at "out of network" benefits. Any questions about medical, well baby/preventive care, labs/x-rays and immunization coverage should be directed to my insurance carrier prior to my visits. I agree to be responsible for all copays, deductibles and non-covered services determined by my insurance plan.

Initial \_\_\_\_ **SELF PAY:** If I do not have proof of insurance coverage at the time services are rendered, I understand that payment is due at the time of service.

Initial \_\_\_\_ **PAYMENTS:** I will promptly pay all amounts that have been determined my responsibility by my insurance carrier upon receipt of my statement. I understand that my health insurance contract is between my insurance company and myself. If my insurance does not pay for the services rendered by the practice doctors within 45 days, the practice may look to me for payment. The practice agrees to refund any overpayment that I have made on my account in the event that my insurance eventually pays. Any balance remaining after my health insurance pays, denies or deems non-covered under my plan will be my responsibility. **If I have not paid my bill or have not arranged for a payment plan, the practice may ask for the assistance of an outside collection agency. If my account is turned over to a collection agency, I will be dismissed from the practice. The practice will try to work with me to avoid this.**

Initial \_\_\_\_ **CHECK IN:** Copays and past due balances are due at the time of check-in. Please come prepared to pay. If you do not have your copay or have not come prepared to pay past due balances, your appointment may be rescheduled for a later time so that you may meet your obligation. Please also bring your current insurance card with you at each visit. For all visits we will ask you to verify insurance and demographic information so that our records remain current.

Initial \_\_\_\_ **APPOINTMENTS & LATE ARRIVALS:** We require patients to arrive on time for their appointments. When patients arrive late, it is impossible to stay on schedule. If you arrive more than 20 minutes past your scheduled appointment time, you may either be rescheduled so that other patients are not inconvenienced or if you prefer to wait, you may be seen when the day's schedule permits.

Initial \_\_\_\_ **NO SHOWS:** We expect patients/parents to give us plenty of notice (usually 24 hours prior) if they are not going keep their appointments. When you make a commitment to an appointment, other patients lose the opportunity of scheduling that date or time, the doctor makes a commitment to you for his/her time, and often times staffing & product orders are arranged.

Initial \_\_\_\_ **MINORS:** Unaccompanied minors must have a written authorization for medical treatment assigned by the parent or guardian before treatment can be rendered. Parents must be available by telephone in the event that the physician needs to contact them. The responsibility for copays, deductibles and fees for no-covered services rests with the accompanying adult.

Initial \_\_\_\_ **SERVICE FEES:** Your account will be charged \$25 for NSF/Returned checks. Patient due balances of 60 days or more (unless previous financial arrangements have been made) may be charged \$10. A non-reversible service fee of 40% may be assessed on your balance if your account is turned to collections.

Initial \_\_\_\_ **EASY PAY:** In order to provide you with the highest quality service while keeping our billing costs low, we offer paperless billing through EASY-PAY. We simply maintain your credit, debit, or check card number on file to satisfy all co-pays, deductibles, and balances not covered by your insurance. Our staff will be more than happy to give you more information about EASY PAY.

I have read, understood and agree to the above financial and office policy. I understand that **Non-compliance with this policy may result in transfer of care to another practice.**

Patient Name \_\_\_\_\_

DOB: \_\_\_\_\_

Patient Name \_\_\_\_\_

DOB: \_\_\_\_\_

Patient Name \_\_\_\_\_

DOB: \_\_\_\_\_

Parent or Guardian's signature \_\_\_\_\_

Date: \_\_\_\_\_