

# FAMILY PRACTICE CENTER, INC.

## FINANCIAL POLICY

It is our sincere desire to provide the best possible medical and obstetrical care for you and your family. This involves a mutual understanding between the patient, the physician and the staff. Considerable care has been taken in setting our fees. Our charges accurately reflect the complexity of care rendered and the skill and expertise required for your care.

All professional services are charged directly to the patient. Insurance coverage has become a very complicated and complex area. Each policy has its own set of rules, guidelines, and benefits. It is vital that you, the patient, understand and know the rules and benefits of your policy.

It is our policy to inform you of our patient payment procedure. Please refer to the section(s) below that is applicable to you.

### \*PATIENT WITH INSURANCE

You are responsible for deductibles, co-pays, non-covered services, coinsurance and items considered "not medically necessary" by your insurance company. The co-pay amount is due as services are rendered. ***The remaining balance is to be paid within 15 days of notice from the office. If you are not able to pay your balance in full, you must call the office and set up payment arrangements. . Insurance card(s) must be presented at each visit.***

### \*MEDICARE

Our office will submit your Medicare charges to Medicare and your secondary insurance. You are responsible for deductibles, co-pays, any non-covered services, coinsurance, and items considered "not medically necessary" by your insurance company. The co-pay amount is due as services are rendered. ***The remaining balance is to be paid within 15 days of notice from the office. If you are not able to pay your balance in full in 30 days, you must call the office and set up payment arrangements.***

### \*PRIVATE PAY

You are responsible for payment on the day service is rendered.

### \*OBSTETRICAL PATIENT

You are responsible to pay the non-covered amount. Payment is due in full by the seventh month of your pregnancy. Benefits will be checked and monthly payments will be set up with you if needed.

### \*AUTO ACCIDENT

You are responsible for the payment on each day the service is rendered. We realize that an insurance company will probably be paying for all medical services rendered as a result of an auto accident, but some of these cases take years until a final settlement is reached. We will give you the proper billing paperwork to file your own claim. ***If you are unable to pay your visits on date of service, you must call the office and set up arrangements with the billing department.***

### \*MEDICAID

**A current Medicaid card MUST be presented at check in before each visit** otherwise the office visit will be a cash visit. No call/no show appointments are your responsibility and are not covered by your Medicaid card. Your HMO provider will be notified.

**\*No Call No Show.** Any 'No Call No Show' will be billed to the patient at an office visit rate. It must be paid before the next office visit is scheduled, or by notification due date which ever comes first.

**\*\*Cancellations** must be done 24 hours prior to appointment time or a \$25.00 fee will be charged and must be paid before your next appointment is scheduled or by notification due date which ever comes first.

We accept cash, check, Money Order, Master Card and Visa. Returned checks (Non Sufficient Funds) will receive an overdraft charge plus a collection charge and **must** be paid before any other visits. If you or your insurance carrier makes payment exceeding your balance, reimbursement will be remitted. In case of hardship, a payment plan may be established through our billing department. A collection agency may take over a delinquent account. If your account is placed with a collection agency, you will be responsible for all costs of collection and services will cease for the family until paid in full. Second time to collection and the family is dismissed from the practice permanently.

I have read and agree to the Financial Policy and understand my financial responsibilities under this policy.

*Any changes in the 'Financial Policy' will be posted at the front desk. Please feel free to review it at any time.*

X \_\_\_\_\_ Name \_\_\_\_\_ Date signed \_\_\_\_\_  
Patient or responsible party *signature* Please print

Additional Family members: \_\_\_\_\_