

## Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please, read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

- 1) **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
- 2) **Co-Payments and deductibles.** All co-payments, coinsurance, and deductibles are due at the time of service. This arrangement is part of your contract with your insurance company.
- 3) **Non-covered services.** Please be aware that some- and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by your insurance company. You must pay for these services in full at the time of your visit.
- 4) **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide is with correct insurance information in a timely manner, you may be responsible for the balance of a claim.
- 5) **Claims submission.** We will submit your claim and assist you in any way we reasonably can to help you get your claims paid. Your insurance company may need you to supply certain information directly. You are responsible for all charges whether or not your insurance company renders payment. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
- 6) **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If you insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.
- 7) **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 day period, our physician will only be able to treat you on an emergency basis.
- 8) **Missed appointments.** Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree by its guidelines.

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Signature of patient or responsible party

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Date