

# FAMILY CLINIC

## Office Financial Policy

**Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. *Please read each section carefully and initial.* If you have any questions, do not hesitate to ask a member of our staff.**

### Appointments

1. We value the time we have set aside to see and treat you. We do not double book appointments. If you are not able to keep an appointment, we would appreciate 24-hour notice. We will waive the first no show occurrence. **However, there is a charge of \$25 for each missed appointment upon the 2<sup>nd</sup> missed appointment.**
2. If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
3. We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
4. Before making an annual physical appointment, check with your insurance company as to whether the visit will be covered as a well visit.

**Initial:** \_\_\_\_\_

### Insurance Plans

*Please understand*

1. It is your responsibility to keep us updated with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.**
2. If we are your primary care physician, please make sure our name or phone number appears on your card. If your insurance company has not yet been informed that we are your primary care physician, you may be financially responsible for your current visit.
3. It is your responsibility to understand your benefit plan with regard to, for instance, covered services and participating laboratories. For example
  - a. Not all plans cover annual healthy (well) physicals, vaccinations, or hearing and vision screenings. If these are not covered, you will be responsible for payment.
4. It is your responsibility to know if a written referral or authorization is required to see specialists, whether pre-authorization is required prior to a procedure, and what services are covered.

**Initial:** \_\_\_\_\_

### Referrals

1. Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days.
2. It is your responsibility to know if a selected specialist participates in your plan.
3. Remember, we must approve referrals before they are issued.

**Initial:** \_\_\_\_\_

### **Financial Responsibility**

1. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and co-insurances.
2. **Co-payments** are due at the time of service. A **\$10 service fee** will be charged in addition to your co-payment if the co-payment is not paid by the end of that business day.
3. Self-pay patients are expected to pay for services in FULL at the time of the visit.
4. If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.
5. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within **10** business days of your receipt of your bill.
6. If previous arrangements have *not* been made with our finance office, any account balance outstanding longer than 28 days will be charged a **\$5 re-bill fee** for each 28-day cycle. Any balance outstanding longer than 90 days will be forwarded to a collection agency.
7. For scheduled appointments, prior balances must be paid prior to the visit.
8. If you participate with a high-deductible health plan, we require a copy of the health savings account debit or credit card, or a copy of a personal credit card to remain on file.
9. We accept cash, checks, Visa, and MasterCard credit and debit.
10. A \$35 fee will be charged for any checks returned for insufficient funds.

**Initial:** \_\_\_\_\_

### **Forms**

1. There is no charge for an insurance form given at the time of your visit. This is considered part of the visit. **However**, should you lose your forms, there will be a \$5 charge (\$5 for one form) to replace them.
2. Any school, camp, or sports forms are subject to a \$25-per-form fee. Family and Medical Leave Act forms are \$25. Disability Forms are \$25. Payment is due when the forms are dropped off. We require 3-day turnaround time.

**Initial:** \_\_\_\_\_

### **Transfer of Records**

1. If you transfer to another physician, we will provide a copy of your medical record and your last visit to your physician, free of charge, as a courtesy to you. We need 48 hours' notice.
2. A copy of your complete record is available for a \$1-per-page fee.
3. We provide records of your visits rendered here at Family Clinic only. For any previous records, you must request them directly from your previous doctor(s).

**Initial:** \_\_\_\_\_

### **Prescription Refills**

1. For monthly medication refills, we require 48 hours' notice, during regular business hours. Please plan accordingly.

**Initial:** \_\_\_\_\_

**I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.**

**Patient Name(s)**

\_\_\_\_\_

**Patient Signature**

\_\_\_\_\_

**Responsible Party Member's Name**

\_\_\_\_\_ **Relationship** \_\_\_\_\_

**Responsible Party Member's Signature** \_\_\_\_\_ **Date**

\_\_\_\_\_

*On completion, we will provide you with a copy for your records.*