FINANCIAL AND PRACTICE POLICIES

Please read and initial beside each item.

INITIALS	ITEM #	POLICY
	1	**Emergencies**: Our providers will make every effort to receive your calls and respond promptly in an emergency. If you do not receive an immediate response, please call 911 or go to the nearest emergency room.
	2	**Prescription Refills**: It is our policy that you should be responsible to know when your medications must be refilled at least a week before you run out. Medications are refilled only at the patient visit or when requested in advance through your pharmacy (this includes mail order prescriptions). **Phone calls for refills should be directed to your pharmacy.**
	3	**Sick Patients**: Patients with acute illnesses will be seen within 24 hours.
	4	**Information**: You agree to provide your correct name, current and correct address, home and cellular number, insurance information, social security number, driver's license, or picture identification at the time of registration or as requested by the practice at any time.
	5	**Financial Responsibility**: By these initials and your signature below, you accept financial responsibility for all charges for services rendered to you. If a minor or under guardianship, the parent or guardian accompanying the patient assumes this liability. ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE.
	6	**Payment Methods**: We accept cash, check, visa, Master and Discover credit cards, and care credit.
	7	**Appointments**: Our office will schedule appointments as a common courtesy for patients and in consideration of your time. Minors must be accompanied by a parent or guardian to be seen in our office. We require a minimum of 24 hours' notice of cancellation as a courtesy to other patients seeking medical service. **A fee of $25 will be charged at our discretion for non-cancelled and missed appointments for established patients. New patients who fail to cancel will be billed $100. A pattern of non-cancelled missed appointments may result in discharge from the practice. If you are more than 15 minutes late, you will be rescheduled.**
	8	**Forms Fees**: Our practice charges for additional paperwork outside of the completion of the medical record. A $15 fee will be charged for forms that must be completed and signed by a doctor.
	9	**Medical Records:** The medical chart is property of the practice. However, copies of your pertinent information is available upon request. We request that you allow at least one-week notification when requesting a copy of your entire medical record.
	10	**Insurance Copayments, Deductibles, and Coinsurance:** Insurance companies do not pay all fees and may exclude certain services from coverage. It is your responsibility to understand your insurance plan. All copayments, deductibles, coinsurance or non-covered services are due at the time of service. If requested, and as a condition of service, you agree to sign an "advanced beneficiary notice" if we determine or question your insurance coverage. You accept responsibility for all such expenses even if your insurance company is billed as a courtesy.

	11	**Usual and Customary**: Some insurance plans may indicate that our fees are above "usual and customary". As a result, your plan may reduce our fee to an "allowed amount" before calculating. This practice does not recognize a specific carrier's use of these terms. As such, unless we have specifically contracted with the carrier, it is expected that you will be liable for the full fees.
	12	**Slow Insurance Response:** You agree that if your insurance company takes more than 60 days to respond to your insurance claim that we shall consider your services your financial responsibility and it will be your responsibility to see reimbursement from your insurance company. ***There will be a $50 refiling fee charged if we have to refile a claim due to receiving the wrong insurance cards from the patient.***
	13	**Accident and Worker's Compensation:** Although our office will be happy to treat your medical condition, if the cause is related to an auto or work-related accident, ***you will be required to pay the full fees at the time of your visit.***
	14	**Statement Policy:** Our office sends patient statements each month. Payments are due upon receipt of the statement. You understand that if we participate with your insurance company the sending of a statement may be delayed until your insurance company responds to a claim for services. Such a delay can take months. You understand that such a delay does not alter our policy of patient financial responsibility and you will be liable for all service fees. A late fee may be charged for patient balances with a minimum charge of $35.
	15	**Collection and Bank Fees:** Accounts more than 90 days old are subject to transfer to an outside collection agency. These agencies charge fees. You agree to be liable for all such collection expenses, legal fees, and court costs. In addition, banks charge for checks that do not clear or cannot be cashed. You agree to be liable for all such fees with a minimum charge of $35.
	16	**Patient Discharge:** The practice reserves the right to discharge a patient for any reason. Please note that discharge may occur for failure to meet your obligations under this document. In addition, because of care quality considerations, the practice may discharge you for failure to comply with treatment plans as outlined by your practitioner.
	17	**Insurance Claims:** If applicable, our office will submit insurance claims. You agree to allow our practice to "accept assignment" of benefits and receive payment directly from your insurance company. In the event your insurer sends payment for a claim from our office to you directly, you agree to remit payment in full for this claim.
	18	Our office contracts with several insurance companies, however, these contracts can change or we may drop out at any time without notice. **WE DO NOT PARTICIPATE WITH THE FOLLOWING CARRIERS:** BCBS Pathway / Pathway X, Amerigroup, and Ambetter.

I have read and understand the terms of this policy and by my initials and signature below, I attest that I fully understand each item and agree to the above terms.

Printed Name: ____ Date: _________________

Signature: ____