Financial Policy/Patient Financial Agreement

The Practice, LLC is committed to serving our patients with professionalism, care and concern. We expect the same commitment from our patients. This includes being on time for your appointments and calling to cancel an appointment in advance if you can't make it. This commitment also includes financial responsibilities, like presenting your identification and insurance cards at every appointment and making your copay and deductible payments at the time of your visit with cash, check or credit card.

Your responsibility is to provide us with accurate and complete information concerning your primary and secondary insurance medical benefits, including documents from other providers. Current identification and insurance benefit cards are to be presented at each office visit. As a courtesy, The Practice will file your insurance claim for you. If you are a Medicare patient, we will bill Medicare and your secondary insurance for you.

For services rendered outside of our office, like radiology, certain laboratory tests, surgery centers, physical therapy, hospitals and rehabilitation centers, it is YOUR responsibility to know which facility you are required to use. If you aren't sure, please speak with your insurance member services or one of our staff before scheduling.

For Medicare patients: Medicare Patient's Signature – I authorize payment to be made on my behalf to The Practice, LLC for any services provided to me by my provider. I authorize my provider to release information needed to determine my benefits.

I understand that my signature authorizes payment be made to pay my claim. My signature also authorizes the release of medical information necessary to file claims with any secondary insurance payer.

Patient Name: (print)____

____ ___________________
Patient Signature Date

I have read and understand The Practice's financial policies and I accept responsibility for the payment of any fees associated with my care.

____ ____________________
Patient Signature Date

Patient Financial Responsibility Contract

Please read, initial each blank and sign where indicated – this document describes your financial responsibilities.

This is a legally binding contract between The *Practice*, LLC and you. The words *I, me, my, you and your* all refer to the patient.

_____ (initial) I agree to be financially responsible for payment of The Practice's services. Cash, check, and credit Cards are acceptable forms of payment for these services.

_____ (initial) Current insurance cards must be presented at every office visit. The Practice is not responsible for filing your insurance claim, but as a courtesy we will do so. I agree to pay the remaining balance after my insurance has paid on my claim immediately upon receipt of a statement.

_____ (initial) I agree to give The Practice my complete and accurate insurance information for primary and secondary insurance benefits including referral documents from other providers, if needed. I understand that if I fail to give complete and accurate information about my insurance benefits, this may result in a denial of my claim or a delay in payment. I agree to pay The Practice the balance on my account after my insurance has been processed.

_____(initial) I understand that I will be responsible for missed appointments or any cancelled appointments in which a 24-hour notice was not given. There will be a fee of $25.00 for any missed office visits and $50.00 for any missed office procedures or physicals.

_____(initial) I understand that there will be a fee of $30.00 for all returned checks, and that if I present a second bad check, my checks will no longer be an acceptable method of payment for me.

_____(initial) I understand that all services provided to me by The Practice are considered medically necessary, if I fail to have a procedure performed or do not comply with my provider's instructions it may be against medical advice and may void my insurance payments. Should this occur, I agree to pay the balance remaining on my account after my insurance has been processed.

_____(initial) If I have a high deductible policy or do not have insurance benefits. I agree to pay an estimate of charges for my office visit in advance and understand that other charges may apply.

_____(initial) The Practice has a contract with my insurance company. The Practice will receive payments from my insurance company for *covered* services provided by my insurance benefits. I agree to pay co-payments and deductibles at the time of service. If co-payments are not made at the time of service, I understand that I may incur a processing fee of $10.00.

_____(initial) I agree to pay any balance remaining on my account after any insurance payments have been paid upon receipt of a statement. I must give The Practice my current address and other contact information. I understand that if I fail to pay the balance on my account this may result in The Practice pursuing any collection means possible.

_____(initial) If my account becomes delinquent, it may be forwarded to an outside collection agency. If this happens, I will be responsible for all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs.

_____(initial) If the reason for my visit is related to a work-related injury or auto accident, I agree to provide The Practice the case number or policy number, the workman's compensation or insurance carrier's name, address or other information necessary to file the claim. If I do not provide this information at the time of service. I agree to pay all charges for my visit.

I have read and I understand The Practice's financial policies and I accept responsibility for payment of any fees associated with my care.

____ _______________________

Patient Signature **Date**