code: EDL001

Financial Policy

First Name _____ **Middle Initial** _____ **Last Name** _____

Thank you for choosing {Company Name}: as your health care provider. Please carefully read and Initial under each statement and sign below. This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager or billing department will be glad to discuss these policies with you.

1. I understand that if I do not have my insurance card, referral, and/or co-payments, that my appointment may be rescheduled until such time that I can provide the required documents or payments.

☐ I Agree

2. I understand that {Company Name} will collect all co-payments at the time of visit and any procedure deductibles and coinsurance up to an amount equal to payment in full for the planned procedure code. Payment in full and expected coinsurance payment responsibility are determined by the anticipated billing code(s), details of your Insurance policy, and agreement between your insurance company and {Company Name}.

Any over-payment to your account will be refunded to you at your request after payment and/or remittance has been received from your insurance company.

☐ I Agree

3. I understand that a $25 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order, or cash.)

☐ I Agree

4. I understand that if I am unable to make a scheduled appointment I need to contact {Company Name} at least 24 hours before my scheduled appointment time. Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of urgent care from being seen.

A $25 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS & $50 FOR MISSED PROCEDURES NOT CANCELED WITH AT LEAST 24-HOUR ADVANCED NOTICE.

☐ I Agree

5. I understand that if my accounts not paid in full within 90 days of a statement date, a 35% collection agency processing fee will be added to the outstanding balance and will be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

☐ I Agree

6. {Company Name} will allow 60 days from the date of filing for my Insurance company to process or pay a claim. State law allows Insurance companies operating in the state no more than 60 days to process claims. It is my responsibility to provide my Insurance company with requested Information needed to process a claim for services. It is also my responsibility to notify {Company Name} If there Is any change in my Insurance coverage, residence, or phone number.

ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS.

☐ I Agree

By signing below, I acknowledge I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by the attending physician.

Signature of Responsible Party:

Date:

ASSIGNMENT OF BENEFITS

We require insured patients to complete assignment of benefits authorizing Insurance to remit payment to physician's office.

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to: {Company Name}. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges where or not paid by said insurance. I hereby authorize said assignee to release all medical information necessary to secure the payment.

Signature of Responsible Party:

Date: