The Family Health Center

OUR FINANCIAL POLICY

We are committed to providing you with the best possible care and would be happy to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility.

If you do not have insurance, we expect payment in full for all treatments at the time of service unless other arrangements have been made. We accept cash, checks, VISA, MasterCard, and Discover. New patients will be required to pay by cash or credit card only, for the first six months.

REGARDING INSURANCE

If you have insurance, we will help you receive maximum benefits. Your insurance claim will ONLY be completed and submitted if we are provided with all pertinent insurance company information. It is your responsibility to verify that your policy is in force on your date of service. Otherwise, you are responsible for payment at the time of service.

Insurance is an agreement between you and your insurance company. We file insurance claims as a courtesy to you, our patient. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurances, “usual and customary” charges, etc., other than to supply necessary factual information. Deductibles and/or co-payments/co-insurances are required at the time of service. You are responsible for the prompt payment of your account. If payment is not received from your insurance company within ninety (90) days, the balance on the account becomes your responsibility.

By signing the form below, you hereby authorize The Family Health Center to bill your insurance company for the services rendered. You further authorize payment of all medical benefits for these services to be paid to The Family Health Center directly.

AGREEMENT

I have read the above Financial Policy and understand that I am financially responsible for all charges whether or not paid by my insurance(s). I understand and agree that my account may be turned over the Credit Bureau for collection after ninety (90) days and that a 33% collection fee will be added to my account

Patient Signature: ______________________________ **Date:** _____ /_____ / ___________

Responsible Party (Please Print): ______________________________

Responsible Party Signature: ______________________________