Clay Platte Family Medicine
Summit Family and Sports Medicine
Cobblestone Family Medicine Clinic
Barry Pointe Family Care

Patient Name: ___________________________
ID#: _________________

FINANCIAL POLICY

Our staff is happy to provide you with quality service and care.

All patients must complete our Financial Policy and Patient Information forms before seeing the doctor.

YOUR INSURANCE INFORMATION AND PAYMENT RESPONSIBILITY: Please have your current insurance ID card available at each visit. If at any time your insurance should change it is your responsibility to inform our office of the change to accurately file your claims.

The cost of medical care is determined by the nature and complexity of your visit. There is no "flat rate" for examinations and treatment. Your insurance plan is a contract between you and your insurance company. As a service to you, our office makes every reasonable effort to obtain payment according to your coverage. It is the responsibility of the patient to understand and know your insurance benefits. Payment for treatment you receive from all our clinic locations is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to our clinics and agree to permit us to release the necessary medical information required to secure your payment. While we will make reasonable efforts to ensure that your insurance carrier properly processes your services for payment, the obligation to enforce the terms of your benefit contract is your responsibility. It is at all times your responsibility to follow up on all requests from your insurance company regarding claims and to question your insurance company about any unpaid claims.

CO-PAYS, DEDUCTIBLES, CO-INSURANCE AND OUTSTANDING BALANCES: All co-payments are due at the time of check- in, prior to your appointment with the Physician. By law we are required to make reasonable efforts to collect deductibles and co-insurance and/or co-payment obligations. In addition, by law, we are responsible to attempt collection of these amounts once they are identified to us on your explanation of benefits. This policy is in accordance with the legal requirements for collecting patient responsibility amounts. All charges are due and payable 60 days from the date of service. Unresolved outstanding balances may be placed with an outside collection agency incurring attorney fees and collection agency fees.

Collections Policy: If you or your families account is turned to our collections agency; you have **90 days** to set up a payment plan or clear your balance at the agency in full. If you have not set up a payment plan with the agency by 90 days, you will receive notice of the intent to withdraw/terminate services from our practice. In order to continue care, collections balances must be paid in full.

Bankruptcy Policy: If we receive notification of bankruptcy proceedings, and we are included in your bankruptcy proceedings, you will be discharged from our practice at the time of notification to our clinic. You will receive a letter with notice of the intent to withdraw/terminate services from our practice. Federal law states that you are unable to accrue charges, including medical expenses during this time, unless it is medically necessary.

PAYMENTS: We accept cash, personal checks, VISA, MASTERCARD and DISCOVER. Payment plans can be set up during check in of appointments on the Phreesia tablets.

RETURNED CHECKS: There is a $40.00 fee for all returned checks.

FORMS: There are many forms that employers and insurance companies need to have filled out for employees. These are not reimbursable by insurances. Examples include FMLA and disability forms. Therefore, there is a charge of $35.00 payable before each form is filled out.

SELF PAY: Self pay individuals will be expected to review and complete our self-pay policy.

Credit Card on File: ______(Initial) A credit card on file may enhance your protection against collection and attorney fees by authorizing the transfer of all unpaid amounts to your credit card after 60 days from the date of services, with or without notification.

AUTHORIZATION: I agree to abide by the terms of the above financial policy and accept responsibility for any balance not covered by my insurance company, therefore, I authorize my insurance company to pay directly to the clinic, and/or provide any information regarding payment of my bill. If my account becomes delinquent, I agree to pay all costs incurred in collecting the account, including a reasonable attorney's fee.

I authorize the physician in charge of to my care administer care as is necessary, including allowing release of records or medical reports on my physical condition to any party involved in my treatment.

By signing below, I acknowledge and understand my financial responsibilities as a patient by signing below.

________________________________ ________________________

Signature of Patient (Guardian) Date

________________________________ ________________________

Signature of Staff Witness Date

1/19/2023