

Our Financial Policy

We appreciate your trust in us and we appreciate the opportunity to serve you. As you may know, our office and physicians in general take great efforts to get insurance companies to pay their share in a timely manner. Often insurance companies inexplicably delay payment to your doctor and, despite your paying increased premiums year after year, they non-negotiably reduce reimbursement payments to doctors. In order to stay in business, we often find ourselves having to make some hard decisions. ***As a result, we have updated our Financial Policy, which we require that you read, agree to and sign prior to any treatment.***

PATIENT PAYMENTS

Payment is due **at the time of service**. You may use cash, check, credit card, or debit card to pay your account. In the event that you wish to be billed, a **\$15.00 billing fee** will be added to your account. Prior to your visit, payment arrangements may be requested in cases of financial hardship.

INSURANCE COVERAGE

We make no claim to know what services your insurance covers. While we make a good faith attempt to verify coverage, we are not able to guarantee that the information given to us by your insurance is correct. It is your responsibility alone to know what insurance plan you are on, supply us with the correct information at the time of your visit and know what services may or may not be covered by your insurance. We encourage you to refer to your benefits manual if you have any questions about covered services. Be aware that some and perhaps all of the services provided may be not be covered by your insurance. You will be responsible for payment of all non-covered services at the time they are rendered. If you did not update your insurance information at the time of your visit, you will be responsible for a **\$25.00 refilling fee**.

INSURANCE PAYMENTS

Regarding insurance, your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We require certain co-payments, deductibles or prepayment amounts depending on the type of insurance and insurance carrier. ***Be assured our office works diligently to obtain payment from your insurance company.*** However, if we file your insurance, and the claim has not been paid for any reason within 60 days, we require that you pay the balance using one of the approved payment methods without exception. In the event that your insurance pays us after that time, you will be reimbursed.

THIRD PARTY PAYORS

Our office does not bill third party payors such as PIP (Personal Injury Protection) for a motor vehicle accident, workers comp or attorneys.

MAIL ORDER PRESCRIPTIONS/REFERRALS WITHOUT OFFICE VISIT/FORM COMPLETION, ETC.

Out of office services have a charge. Our office charges **\$5.00** for each mail order pharmacy prescription or referral written without an appointment. Please obtain any written prescriptions while you are here to see the doctor. Forms completed outside of an office visit may be subject to a fee ranging from \$25 to \$45 depending on complexity.

ESTABLISHED PATIENTS / MISSED / LATE CANCELLED APPOINTMENTS

Please give us at least *24 working hours* notification if you cannot keep an appointment. This courtesy will allow others to be seen. We do realize that emergencies arise; however, after **two (2) Late Cancels or No-Shows**, you will be notified by mail that this behavior cannot continue or our relationship will have to be terminated.

NEW PATIENTS / MISSED / LATE CANCELLED APPOINTMENTS

We require twenty-four (24) *working hours* notification if you cannot keep an appointment. This courtesy will allow others to be seen. You are notified when you are booking your New Patient appointment that you will be **billed a \$50.00 late cancel / no-show fee for a 30 minute appointment and \$75.00 late cancel / no-show fee for a 45 – 60 minute appointment.** There are no exceptions.

RETURNED CHECKS

Our bank charges us whenever a patient presents a check that does not have funds available. Therefore, we must charge you a \$35.00 handling fee. All future visits will need to be paid with either cash or a credit card.

We welcome the opportunity to discuss any aspect of our financial policy. Please ask to our office manager or assistant office manager if you have any questions, comments, or concerns. We sincerely regret having to maintain such a policy and hope you understand our reasoning. This authorization shall remain valid until and unless revoked by either party in writing and may be updated at any time without notice. We thank you for your support, and look forward to serving you in the future.

-Patient Authorization-

I have read, understand, and agree to abide by the terms stipulated above. (Please read our patient brochure available at the receptionist window for more information about our practice.) I request that payment of benefits be made to West Lake Family Practice. I hereby authorize the release of any information necessary to determine liability for payment and obtain reimbursement on any claim. I further authorize the use of my signature below on all insurance submissions for services rendered or to be rendered. I agree that a photocopy of this agreement shall be as valid as the original.

Patient Name _____ Date of Birth _____

Patient Signature (or Parent of minor/Legal Guardian: **X** _____ Date: _____

Name of person completing form if other than patient: _____ Relationship to Patient: _____