COAL CREEK FAMILY MEDICINE
FINANCIAL POLICY

1. Co-payments are due at the time of service. We may ask that non-emergent appointments be rescheduled if you do not have your co-pay. Please send cash, check or a credit card number with your child. All children under the age of 18 must be accompanied by an adult or written consent from a parent. If your co-pay is not paid at the time of service, you will be billed a $10 fee in addition to your co-pay.

2. All Visits or services that are applied to a deductible, or are not covered by your insurance, are the financial responsibility of the patient and must be paid within 30 days after your insurance has denied payment to us. If your account reaches 60 days past due, a finance charge of 18% APR will be added to your account with each billing period that the account remains unpaid. If you disagree with or question your monthly statement please contact our billing office at 303-666-0127. All accounts that are 90 days past due may be sent to an outside collection agency. If we are forced to proceed with collection actions, a fee of 25% of the account balance will be added to your account to cover the collection costs.

3. The Statement you receive from our office will include visits for all members of the family and will be addressed the "Guarantor" of the account, which by default will be the person who holds the insurance. If this is not correct, please inform us at each and every visit of who the guarantor should be for that visit. If there are any legal agreements between divorced or separated parents, please make us aware when selecting your guarantor. Documentation must be provided.

4. It is the patient's responsibility to know their insurance coverage. If you are not in agreement with your insurance company, you must pay the bill and submit it to your insurance for reimbursement. We will be glad to help you resubmit a claim to the insurance company after you have paid for your services.

5. A copy of the patient's insurance card is required on each and every visit to us. It is the patient's responsibility to make sure that any insurance information given to our office is correct and current. Failure to provide such information will result in patient financial responsibility for all services provided.

6. Any time the patient sees a provider outside our office which requires a referral, the patient agrees to notify the office at least 72 hours before the appointment or the patient will be financially responsible for those services provided at another office.

7. If the patient fails to cancel a scheduled appointment with this office at least 24 hours prior to the appointment, the patient can be charged a minimum of $25.00 for that missed appointment. It will not be billed to the patient's insurance and will be the patient's personal responsibility.

8. Any personal check returned to the office for insufficient funds will have a $25.00 service charge added and all subsequent visits will need to be paid with cash, credit card or certified funds.

9. Any medical records that are requested to be copied by someone other than yourself or another physician will require a payment of $25.00. This request will take a minimum of 2 weeks to be completed.

I have read and understand the above policy

_____ _____

Patient Printed Name Date of Birth

_____ _____

Patient Signature, Guardian if a Minor Today's Date