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 cc 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 assessed a $10 fee in addition to your co-pay. (Initial) _____

2. I hereby acknowledge and agree that I am voluntarily seeking health care services from Coal Creek Family Medicine and its providers. I understand and agree that payment for the services I receive is my responsibility. I understand and agree that Coal Creek Family Medicine may bill my insurance/third-party payor or other responsible insurance as a courtesy but is not obligated to do so. (Initial) _____

3. 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. (Initial) _____

4. Self-pay patient's - I understand that I will be responsible for all charges related to the services provided to me by Coal Creek Family Medicine. **I understand that the charges presented to me are due in full on the day of service**. I also understand that these charges are solely in relation to professional services provided by the physician, and or other services that are performed in the office. I will also be responsible for all fees billed to me separately from the Laboratory. These charges will be about all lab work up required to be sent to the Lab. All other services that require you to go elsewhere such as x-rays, MRI's, CT's, etc., are not included in your fee. You will be billed separately for these services from the practicing location. (Initial) _____

5. I understand that Coal Creek Family Medicine may charge me fees for cancellations with less than 24 hr notice or failure to show up for a scheduled appointment. For office visit appointments ($50 fee) for wellness exams/complete physical appointments ($75) and for a procedure appointment ($100). **I understand and agree that all fees are due when assessed and must be paid before another appointment will be scheduled**. I also understand and agree that a third no-show or a third cancellation with less than the required minimum notice may be grounds for discharge from Coal Creek Family Medicine. (Initial) _____

6. I understand that if any personal check returned to the office for insufficient funds will have a ($25 fee) and all subsequent visits will need to be paid with cash, credit card or certified funds. (Initial) _____

7. I acknowledge, understand and agree that it is my sole responsibility to determine what my health insurance covers, whether the health care provider I am seeing is a participating provider under my health insurance, and whether my health insurance covers the health care services I receive from or through Coal Creek Family Medicine. I understand and agree that I am solely responsible for payment of my entire account balance. (Initial) _____

8. If you schedule a well visit, also known as a complete physical, and issues other than wellness are discussed, a copay will be required for that visit if your insurance requires one. If you would like more detailed information, please ask the front desk. (Initial) _____

9. In the event of failure to pay for medical services rendered or fees assessed, I understand that I may be discharged from the services of Coal Creek Family Medicine. Additionally, I understand that I may be referred to a collection's agency for nonpayment of amounts due for services rendered by Coal Creek Family Medicine or fees assessed. I understand that I will be responsible for a collection fee of $25 and all agency and attorney fees and costs associated with the collection process (such as court costs) and that these fees and costs will be added to my account balance. (Initial) _____

10. Any medical records that are being requested to be copied will require a flat fee of $25.00. This request will take a minimum of 2 weeks to be completed. (Initial) _____

11. If there are any legal agreements between divorced or separated parents, please make us aware immediately. Court Ordered Documentation will need to be provided to be scanned into your child's records for your protection and ours. However, it is the responsibility of the person bringing the child to the appointment to pay any co-pay as it is due at the time of service regardless of any financial ruling. (Initial) _____

I have read and fully understand this financial policy

Printed patient name _____ Date of Birth: _____

If patient is a minor name of parent or legal guardian _____

Signature of responsible party _____ Today's Date _____