Coal Creek Family Medicine

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FINANCIAL POLICY

___1.) **INSURANCE**: Your health insurance policy is a contract between you and your health insurance company. It is your responsibility as the policy holder/patient to understand your coverage and benefits and be knowledgeable of any deductibles or co-payments, to verify that your physician is in-network and that medical services we provide are covered under your plan. Please provide us with your current insurance information at the time of scheduling each visit and notify us of any changes. Additionally, you will need to bring a copy of your insurance card with you at every appointment. Failure to provide such information will require you to be self-pay, and you will be fully responsible for all services provided at the time of service.

___2.) **SELF-PAY PATIENTS:** Self-pay patients are those patients without insurance coverage or are receiving a service not covered by their plan. Payment for medical services is due at the time of service. Please leave your payment information with the front desk before your appointment.

___3.) **PAYMENTS:** All co-payments and past due balances are due at the time of service. This arrangement is part of your contract with your insurance company. A $10 fee will be assessed for any co-payment not made at the time of service.

___4.) **LATE CANCELLATIONS OR NO-SHOWS**: Our office policy requires at least a 24-hour notice of cancellation for booked appointments. Failure to provide adequate notice may result in a missed appointment fee from your physician. The fees are as follows: office visits ($50 fee), wellness exams ($75 fee), procedures ($100 fee). Fees must be paid before another appointment can be scheduled. A third no-show or cancellation with less than the required minimum notice is grounds for discharge from our practice.

___5.) **BILLING**: Our policy is to send one statement when your account has any patient responsibility due. After 30 days, if the bill remains unpaid, we will charge your credit card for any balance of $250.00 or below and will be charged every 30 days until the balance is paid in full. CCFM will charge a $5/monthly late fee to all past due accounts without a credit card on file. Failure to receive payment after 60 days past due will result in your account being sent to collections. You will also be responsible for all fees and costs associated with the collection process and you will be discharged from our practice.

___6.) **CREDIT CARD ON FILE AGREEMENT**: A credit card is **REQUIRED** to be kept on file to cover any outstanding patient responsibility. This card can be used to pay co-pays and balances that are more than 30 days past due. Failure to keep an active credit card on file will result in a $5 statement fee should you have a balance you are billed for.

___7.) **ANNUAL ADMINISTRATIVE FEE (AAF):** Annually all patient accounts will be accessed with a $15 fee that is required to be a patient of the practice. The AAF is intended to cover services such as after-hours communications, maintaining medical records, prior-authorization, completion of immunization records, third-party medical forms, insurance filings and applications, email correspondences, etc.

___8.) **PERSONAL CHECKS:** If you have a returned check for insufficient funds, you will be assessed a ($25 fee) and all subsequent visits will need to be paid with cash, credit card or certified funds.

___9.) **LEGAL AGREEMENT**: If there is a legal agreement between divorced or separated parents, please notify us immediately. For your protection and ours, we request that you provide us with any court-ordered documentation so we may scan it into your child's record. 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. **MINORS**: All children under the age of 18 must be accompanied by an adult or with written consent from a parent. Please send cash, check, or CC with your child.

___10.) **AFTER HOUR CALLS**: Our providers are available 24 hours a day. You can have our on-call physician paged after hours for an urgent medical need. This call will likely incur a charge for an afterhours visit or a telephone consultation. Any co-pays or deductibles will be applied based on your insurance policy.

I ACKNOWLEDGE AND AGREE TO ABIDE BY THE GUIDELINES OF THIS FINANCIAL POLICY.

Printed Patient Name: ____________________ Date of Birth: ____________________

Signature of Patient or Legal Guardian: ____________________ Date:____________________