IMLAY CITY FAMILY PRACTICE

6672 Newark Road Imlay City, Michigan 48444
810-724-0591

OFFICE FINANCIAL POLICY

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Please ask if you have any questions or concerns regarding our fees or financial policy. Full payment is due at time of service. We accept cash, checks, Mastercard, Discover and Visa and HSA and FSA accounts. A $25.00 fee is assessed for returned checks.

INSURANCE

We participate with many insurance companies and will bill insurance directly for services provided. Understand that your insurance policy is a contract between you and your insurance company. In order to bill your insurance, we need a copy of your **current insurance card(s) and a copy of a valid state ID or driver's license.** <u>We will be unable to bill for services if current information is not provided and services will become the responsibility of the patient.</u> **Preventative care (annual exams) and well child/immunizations** are submitted according to insurance billing guidelines

UNDER NO CIRCUMSTANCES will we change a procedure or diagnosis code to receive payment from insurance, as this is considered **FRAUD**.

PATIENT RESPONSIBILITIES

- To know his/her copay and benefit coverages such as office calls, preventative care and immunizations
- To pay for services when they are rendered. Payments from HSA and FSA accounts are accepted.
- To provide current insurance information. If not available then it will be considered **NO INSURANCE** and you will be charged as a cash patient. We will be happy to provide you with an itemized receipt to submit to your insurance for your reimbursement.
- Financial responsibility for services rendered to minor patients belongs to the **parent/guardian with custody.** That parent/guardian has the responsibility to collect from another party if necessary.

MISSED APPOINTMENTS: A $50.00 fee may be assessed for missed appointments.

TESTS/PROCEDURES: Some insurances require that their contracted patients use a specific lab or imaging company or a particular facility for immunization administration. THIS CONTRACT KNOWLEDGE IS PATIENT RESPONSIBILITY and <u>your insurance company may apply more of the balance to your responsibility</u> if you complete your testing here. At your request, we will gladly give you an order so that you can have a test or procedure done elsewhere.

UNPAID BALANCES:

- A balance remaining outstanding for more than 90 days with no payment arrangements made may be turned over to collection. This may affect your credit.
- Accounts in collection may result in discharge from the practice, which means that you will have to find a new physician.
- **MISSED APPOINTMENTS:** Charges may be made for broken appointments and appointments cancelled without 24 hours notice. In some circumstances we may be forced to discontinue your care if you do not keep your scheduled appointments.

I have read and understand the financial policy of the practice and agree to be bound by its terms. I understand that those terms may be amended at any time by the practice. I authorize the release of medical information as necessary to process insurance claims, insurance applications, prescriptions, medical testing, therapy, and for continuity of care coordinated with other physicians/health care providers.

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Signature of Patient or Responsible party if a Minor **Date**

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Printed name of Patient **Rev 8/2018**