Patient Payment Authorizations and Policies

I, the undersigned, authorize payment of medical benefits to Family Medicine, PC for any services furnished to me. I understand that I am financially responsible for any amount not covered by health insurance. I also authorize Family Medicine, PC to release to my health insurance company any information concerning my healthcare, advice, treatment and/or supplies provided to me. I also understand that a copy of this authorization can be used in place of the original.

_____
Patient Printed Name

_____ _____
Patient Signature Date

Co-pays and deductibles are due at the time of service
All co-payments, deductible and coinsurance policies are due in full at the time of service. Any payment arrangements must be requested and approved by Family Medicine, PC's **billing** manager. If payment arrangements have been made, you are asked to abide and pay according to the schedule. We accept cash, Visa, MasterCard, American Express and Discover. Checks are not accepted, unless for a balance on an account. All returned checks will incur a $35.00 fee.

_____ initial

You and your health insurance
We participate with most health insurance plans. We will bill your health insurance company as a courtesy to you and will assist in any way reasonable to help get your claims paid. Although we may estimate what your health insurance company will pay, it is the health insurance company that makes the final determination of your benefits and eligibility. Your health insurance company may require you to supply certain information directly. It is your responsibility to comply with their request. Please be aware the balance of your claim is your responsibility.

All patients must complete our patient forms before seeing our providers. We must obtain a copy of your driver's license and current, valid health insurance information. If we do not you may be responsible for the balance of the claim. You must notify us immediately if your health insurance changes, so we may update your record.

_____initial

Account balances

If you have an unpaid balance, you will receive a statement by mail, email, or text every month. Payment is due upon receipt and all payments made are applied to the oldest outstanding balance. Balances over **6 months old** **Subject of being turned over to a Collection Agency.** The guarantor (the person responsible for paying the bill) will be responsible to pay all costs of collections, including reasonable interest and reasonable collection fees.

_____initial

Late Cancelation and No-Show Appointment Policy
Please allow a 24-hour notice for any appointment cancellation to avoid a $50.00 no-show fee. Any late cancellation notice (less than 24-hours) is considered a no-show and subject to the same $50.00 fee. If you have two no-shows in one year, you will receive a notice from the billing department. After a third no-show in one year, you may be excused from the practice. Regretfully, we have been forced to institute this policy due to a large volume of same day cancellations.

_____ initial

Zero tolerance for abuse and foul language towards staff or other patients
Any act or threat of physical violence, harassment, intimidation, foul language, or other threatening disruptive behavior from any patient or guest is unacceptable and will result in immediate dismissal from Family Medicine, PC. Legal action may be pursued.

_____initial

I acknowledge and agree to abide by Family Medicine, PC's Patient Payment Authorizations and Policies. I may ask for a copy of Family Medicine, PC's Patient Payment Authorizations at any time, free of charge. I also understand I can ask questions about Family Medicine, PC's Patient Payment Authorizations at any time.

_____
Patient Printed Name

_____ _____
Patient Signature Date