Patient Information

Name _____Date of Birth ____/____/_____ Age_____ Sex_____

Address _____

City _____ State _____ Zip_____ SSN_____

Home Phone _____Cell Phone _____

Last Family Doctor _____

Preferred Pharmacy Name _____Phone _____

Payment Policy

Thank you for choosing us as your care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have, and sign in the space provided. A copy will be provided to you on request.

1. **Insurance:** We **do not** participate in any Insurance plans at this time with the exception of coverage for Lab Fees. Cash or Credit Card Payment in full is expected at each visit. If you are insured by a plan we do business with, we need a copy of an up-to-date insurance card so we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Claims Submission:** We will submit your claims for Lab Fees and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company, we are not party to that contract.

3. **Coverage Changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

4. **Non-Payment:** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this were to occur, you would receive a notice via regular and Certified Mail that you have 30 days to find alternative medical care.

5. **Missed Appointments:** Our policy is to mail out a letter to your home after your first missed appointment explaining that we have a three missed appointment policy. The first letter will be one to let you know that an appointment has been missed and explains future missed appointment policies. The second missed appointment letter lets you know that a fee of $25.00 will be charged to your account. The third missed appointment letter will let you know that we will be discharging you from the practice.

6. **Service Charges:** Service charges are necessary to help reduce the overhead expense associated with providing services between office visits and also for certain Administrative Services. The following service charges have been implemented.

Request for the completion of forms by the Patient:	**$ 20.00 per Form**
Request for the completion of forms or a letter by an attorney.	**$350.00 per Request**

Signature of Patient _____ Date _____/_____/_____