FINANCIAL POLICY

PATIENTS NAME: _____ **DATE OF BIRTH:** _____

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

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until 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.

   NO INSURANCE. ***If you are not insured by an insurance company, payment in full is expected at each visit. You are expected to pay at check in which will be held as your deposit toward your visit. If charges exceed your deposited funds, additional payment will be collected at check out.***

2. **Co-Payments and Deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contact with your insurance company. Failure on our part to collect copayments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copayment at each visit. No post-dated payments will be allowed. There is a $35.00 fee for all returned checks.

3. **Non-covered services.** Please bee aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. **Proof of Insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your State issued identification and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the entire balance of the claim.

5. **Claims Submission.** We will submit your claims 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 a party to the contract. We will bill your insurance company as a courtesy. Deductible or co-insurance are established by your insurance company, are not a guarantee of benefits and will be subject to final determination of benefit limitations by your insurance company when they process your claim.

6. **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 45days, the balance will automatically be billed to you.

7. **Nonpayment.** You will receive a statement of account every 30 days. The statement will identify any previous balance from your last statement, any new activity within the last 30 days, with a current balance which is due in full upon receipt of the statement. 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 payment will not be accepted unless otherwise negotiated in writing. 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 is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 day period, our physician will only be able to treat you on an emergency basis and full payment for the emergency care must be made at the time of the visit. ***Waiver of Confidentiality: If the account is transferred to collections, your past due status may be reported to a credit reporting agency. The fact that you received treatment at our office will become a matter of public record.***

8. **Missed Appointments.** Our policy is to charge for missed appointments not cancelled within a reasonable amount of time which we consider to be a minimum of 4 hours prior to the appointment time. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment.

9. **Divorce.** In case of a divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible. The parent who authorizes or consents to treatment for the child will be responsible for the charges on the date of service and will also be responsible for collecting from the other parent.

10. **Transfer of Records.** At your written authorization, we will provide a copy of your patient record to another physician within 30days at no cost to you. If you choose to pick up those records, there will be a fee which must be paid in full prior to release of records.

11. **Personal Injury.** Please be aware that some or all of the services you receive may not be covered by your insurance company. You will be responsible for payment in full at the time of the visit. We will not bill any third party or attorney for charges incurred due to personal injury

12. **Workers Compensation.** We are not authorized to provide services for workers compensation injuries. Please be aware that if you provide fraudulent information concerning origin of the injury, your corkers compensation benefits may be affected.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns. This is an agreement between Barri Hoffman, FNP, PLLC d/b/a Head to Toe Family Healthcare as creditor, and the Patient/Guarantor as debtor named on this form. By executing this agreement, you are agreeing to pay for all services that are received. **I have read and understand the payment policy and agree to abide by its guidelines.**

_____ _____

Signature of Patient or Responsible Party Date