Wattles Park Family Practice

Patient Financial Policy

Thank you for choosing Wattles Park Family Practice as your health care provider. In order to reduce confusion and misunderstanding we have adopted the following financial policy. If you have any questions about the policy, please discuss this with our billing office. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element to your care and treatment.

Unless prior arrangements have been made by either you or your health coverage company, full payment is due at time of service. If you have no insurance coverage or non-contracted insurance coverage full payment is due at time of service. We accept Cash, Checks Visa, Master Card and Discover.

Indemnity Insurance: Your insurance policy is a contract between you and your insurance company. You are responsible for 100% of your charges. As a courtesy we may bill your insurance company on your behalf for minor office surgeries, care/treatment at the office and hospital services. Please be aware that some, and perhaps all, of the services provided may be non-covered and not considered reasonable and necessary under your medical plan. It is your responsibility to know your insurance coverage and benefits and to provide us with that information. We need you to provide us with your Social Security number.

Contracted Plans: We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits, this means that you will only be responsible for your co-pay at the time of service. We will bill your insurance for the remainder of your charges.

Minor Patients: The adult accompanying a minor (parent or guardian of the minor) is responsible for full payment of co-pay and deductible amounts. If unaccompanied by an adult the co-pay will be collected by the minor. We do not become involved in court ordered medical reimbursement. Payment is the responsibility of the accompanying adult or custodial parent.

Assignment of Benefits: I hereby assign payment of authorized Medicare and any other medical and/or surgical insurance company benefits, to include manor medical benefits to which I am entitled, to be made either to me or on my behalf to Dr. Henry for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release information needed to determine these benefits payable for related services. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Fees: I understand that if I miss an appointment and do not provide 24 hour notice for cancelling an appointment I will be charged $40.00 dollars and will be responsible to pay that amount prior to being seen. A $35.00 service fee will be assessed for any outstanding balance sent to collections.

_____ Date _____

Patient Signature **OR** Responsible Party

_____ DOB:_____ Date_____

Patients Name Printed

_____ Date_____

Witness

RECIEPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

This signed document serves as acknowledgement of the location of the notice of Privacy Practices with in our office which is located at the receptionist desk for you to review and/or obtain. Questions regarding the Notice of Privacy or confidentially issues should be directed to the Privacy Officer.

_____ Date_____

Patient Signature **OR** Responsible Party