

**Practice Name
Address
Phone Number / Fax Number**

FINANCIAL POLICY

As your physician, we are committed to giving you the best possible medical care. To achieve this goal, we need your assistance and understanding of our payment policy.

We ask that all services be paid at time of service. If you have insurance, please present your insurance card for verification. If your insurance changes, please notify us immediately.

BLUE CROSS/BLUE SHIELD PPC (_____): As providers with PPC of _____, we ask that the co-pay and deductibles (if applicable) be paid in full at the time of your visit. We accept assignment for services covered and will bill the insurance. Any balance outstanding following payment from the insurance, will be billed to you.

MEDICARE: We are participating Medicare providers, and we will file Medicare for you. Any service routinely not covered by Medicare (i.e., Preventative/Routine Exams) we will request that the services be paid at time of service. We request payment for the 20% of the allowable Medicare charges and any deductible (if applicable) that has not been met at the time of your visit.

PCA MANAGED CARE: We are NOT providers of any Managed Care program except PCA Managed Care. If you are a member of a Managed care program, and choose to see us as your physician, please be prepared to pay for services at the time of your visit. Or, if your physician has referred you to us, please verify **BEFORE** your appointment that we have received the authorization for payment.

WORKER'S COMPENSATION AND AUTO INSURANCE: We do not participate in the treatment of illnesses in Worker's Compensation claims. Nor do we handle the initial emergency care from automobile accidents.

FINANCIAL AGREEMENT: We will be glad to discuss your proposed treatment and the cost of those services. If you have questions if your insurance will cover a medical service, we will be glad to try to find out if the insurance will cover for those services. HOWEVER, please be aware that your insurance is a contract between you, your employer (if applicable) and the insurance company. We are not a party to your contract. Unfortunately, not all services are covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover (e.g., yearly physicals)

We must emphasize that as your physicians, our relationship and concern is with you and your health, not with your insurance company. **ALL CHARGES FOR SERVICES ARE YOUR RESPONSIBILITY AT THE TIME OF THE SERVICE.** On any balance on your account after 90 days, collection action will be taken. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact our insurance office promptly for assistance in the management of your account. There will be a \$3.00 monthly charge added to any accounts that have an outstanding balance after sixty days following insurance payments.

If you have any questions regarding the above, or any uncertainty regarding insurance coverage or request for payment, please do not hesitate to ask. We are here to help you.

I HAVE UNDERSTOOD AND AGREED TO THE FINANCIAL POLICY FOR (Practice Name).

Signature

Date

Witness

Date