Complete Family Medicine

Financial Policy

Patient Name: _____ Date of Birth: _____

Basic Policy – Payment is due in full at the time of service is provided in our office.
Types of Payment Accepted: Cash, Visa, Master card, Discover, Credit or Debit. (We do not accept checks or American Express)

Patients with Insurance – As a courtesy and if proper paperwork is provided to us we will bill your primary insurance carrier. Copayments and deductibles are due at the time of service. Your agreement with the insurance carrier is between you and your insurance company, and as such we do not routinely research why an insurance carrier has not paid, or not paid per contracted agreement. If your insurance carrier has not paid within 60 days from date of billing, you will be responsible for any outstanding balance.

Non-Covered Services – Any services provided which are not covered under your insurance plan must be paid in full at the time of your visit or upon notice of insurance claim denial.

Personal Injury Cases – This office does not bill for auto accident or other liability or lawsuit – related cases. You are responsible for payment at the time of service.

Workers Compensation – This office does not bill for work related injury, if you are treated for such you will be responsible for payment in full at the time of service.

Missed Appointments – In fairness to other patients and the doctor, we require at least 48 hours' notice to cancel an appointment. Failure to do so will result in a ***$50.00*** "Late Cancel/Missed Appointment" fee being charged to your account. If you fail to cancel a scheduled appointment more than twice, you will be dismissed from the practice.

Service Charge – 2% per month may be added to any outstanding balance over 60 days old.

Delinquent Accounts – If your account is not paid as per our request, it will be turned over to a collection agency and a 30% fee will be added to the entire balance. This amount will then have to be paid in full before any further appointments can be made.

Assignment of Insurance Benefits – Please read and sign below. I hereby give my insurance carrier authorization for payment of insurance benefits to be paid directly to "Complete Family Medicine" for services rendered. I understand that I am financially responsible for all charges whether or not paid by said ins. I further agree to the release of any information necessary to process my claim and that a photocopy of this agreement shall be valid as the original. I hereby certify that I have fully read, understand and agree with all terms and conditions.

↘ Signature of responsible party: _____ Date: _____