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BOARD CERTIFIED INTERNAL MEDICINE
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Patient Financial Policy Sheet (Revised 06/2024)

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss with our Billing Manager. We are dedicated to providing the best possible care and service to you and regard your understanding of your financial responsibilities as an essential element to your care and treatment.

- ***Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience, we accept check, cash, Visa, Discover, Amex or MasterCard.***

Your Insurance:

- We have made prior arrangements with many insurers and health plans, to accept assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment.
- Each month you will receive a monthly statement for services, which is due and payable within 30 days. If your payment is late, or if you have not previously made financial arrangements, then we will mail a reminder notice indicating there is a problem with your account. If you are experiencing a set of circumstances out of your control, please call our practice and we will be happy to make special arrangements.
- Not all services are a covered benefit in all insurance plans. Some health plans select certain services that they will not cover. In the event that your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment of balance that is designated as the patient's responsibility is due upon receipt of a statement from our office.
- We will bill your health plan for all service provided in the office or hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.
- There is a fee of $25.00 assessed for insufficient funds in addition to the fee from your financial institution.
- For all services rendered to minor patients, we will look to the adult accompanying the patient, and the parent/guardian with custody for payment.

Please Note: In the event my account is referred to an attorney or collection agency, I agree to pay for processing or convenience fees, if required as a cost of collection of my account. I understand such fees would only be incurred if I optionally choose to pay the account by credit card or check by phone to the attorney or agency.

I have read and understand the financial policy of the practice, and I agree that the practice may amend such terms as necessary.

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Print Patient Name

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Signature of Patient or Responsible Party **Date**