**PATIENT FINANCIAL POLICY**

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or manager.

As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office. Unless other arrangements have been made in advance by you or your health insurance carrier, payment for office services are due at the time of service.

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to us. In other words, you agree to have your insurance company pay Dr. Hursey/Sandhills Internal Medicine directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.

We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.

If you have insurance coverage with a plan with which we do not have a prior agreement, you will be responsible for **ALL** charges for your care and treatment at the time of service.

**All health plans are not the same and do not cover the same services. Dr. Hursey orders what she feels is in your best interest, but your insurance company wants to pay as little as possible for your care. In the event your health plan determines a service to be “not covered”, or you do not have an authorization, you will be responsible for the complete charge.**

We will attempt to verify benefits for some specialized services; however, you remain responsible for charges for any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

You must inform the office of all insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.

There is a service fee of **$45.00** for all returned checks. Your insurance company does not cover this fee.

**Late Cancellations and No-Show Policy:**

Your time is valuable, as is ours. We reserve spaces on our scheduling template to provide medical care for you. When you do not show up for your appointment or cancel within 24 business hours of your appointment, you have taken valuable time from other patients that may have needed medical attention.

**Late Arrivals:** Arriving late for your appointment affects every appointment following yours. We will attempt to accommodate late arrivers, but this may not always be possible and would constitute a no-show visit.

Your insurance carrier cannot be billed for late cancellations, no shows or for late arrival cancellations.

Late cancellations/No show fee for routine follow up or sick visits **- $75**

Late cancellations/No show fee for annual wellness or physical exams **- $150**

**ALL LABS AND IMAGES WILL BE DISCUSSED IN THE OFFICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.**

PATIENT SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT PRINTED NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LEGAL REPRESENTATIVE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_