Patient Name: _____ Account Number: _____

Family First Physicians Financial Policy

Family First Physicians is committed to providing quality medical services to our patients and clearly defining our financial policy. If you have any questions, please ask for a **billing staff member** for assistance.

Please initial all items and sign page two:

_____ 1. **Insurance:** It is extremely important that you furnish us with accurate and updated information. If changes occur in your insurance policy or you may have additional information, such as **secondary** insurance, please make sure to provide our office with all the information and changes. This will ensure that your file has the most up-to-date information possible. Incorrect information could result in the denial of your claim. If this occurs, you assume responsibility for the entire amount of the claim.

   i. Please be aware that if you have an AHCCCS plan, it is **ALWAYS** the payer of last resort. Any other health insurance plan must be billed prior to AHCCCS. This means that if you do not provide our office with your primary insurance information, AHCCCS will not pay.

   ii. Please be aware that our will submit a claim for worker's compensation if authorization to treat you at Family First Physicians has been given. It is the patient's responsibility to provide our office with employer authorization/contact information regarding a worker's compensation claim. If the claim is denied by the worker's compensation insurance carrier, it then becomes the patient's responsibility.

_____ 2. **Non-Covered Services:** All health plans are not the same and they do not always cover the same service. Please be aware that some of the services you receive may be determined "not covered" by your health plan. You must pay for these services in full within ninety (90) days. If you have questions as to what services are covered, contact member services (the number is listed on your insurance card.) **It is your responsibility to be aware of your benefits, we do not quote or verify benefits.**

   i. A "No Show" fee of $50 will be applied to any visit that is not canceled or rescheduled 24 hours prior to the appointment time. We understand emergencies happen, but when they do, please contact our office as soon as possible to potentially avoid any fees. No show fees will be waived at the discretion of management.

_____ 3. **Billing Dept Information:** A claim for services will be submitted to your insurance within 45 days of your visit. You should receive an explanation of benefits (EOB) from your insurance company explaining what they paid. As a courtesy, our office will send three (3) monthly statements to the responsible party for any balance remaining.

   i. Bills that are delinquent for more than ninety (90) days will be transferred to an outside collection agency unless prior arrangements have been made.

Payment is due at the time of service. If you do not have your co-pay, your visit may be rescheduled. We recognize the need to set up payment plans for patients who require extensive treatment.

   i. We accept cash, check, money order, VISA, and MasterCard. Any check returned to our office by the bank will be subject to an additional $25 service fee and our office will no longer accept payments via

personal check.

ii. Our billing department will be happy to help you with these arrangements. Any payment arrangement made but not kept current will be voided with the balance being due in full and will result in the termination of this option in the future. Any payments made will be applied to oldest balance first.

_____ 4. **Motor Vehicle Accident and 3rd Party Billing:** We do not offer any third-party billing. Our relationship is with you and not with the third-party liability insurance (auto, homeowner, etc.) It is your responsibility to seek reimbursement from them.

_____ 5. **Form Fees:** An administrative fee of $35-$75 per form will be charged for any forms that need to be reviewed and filled out by our physicians. This includes but is not limited to FMLA or disability forms, sports physicals, mission physicals, etc. If you like to request your records a medical records release form will need to be filled out prior to initiate the request and an administrative fee of $25 will be charged. This does not apply to laboratory or imaging reports.

_____ 6. **Responsible Party**: If the patient is a minor, the person signing these forms agrees to be listed as the Guarantor and accepts sole financial responsibility for services rendered by Family First Physicians.

Please feel free to discuss any concerns you may have with our office staff. Our staff is dedicated to making your visits with us as pleasant as possible. It is your responsibility to know what is covered by your insurance plan as well as being financially responsible for any services denied or not covered by insurance.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of service. Our office will not bill any other personal party.

I agree to pay all finance charges, late fees, collection costs, attorney fees, and any other costs that may be incurred to enforce collection of any amount outstanding. I have read, understand and agree to the financial policy stated above and accept responsibility for all payment of all fees/charges incurred with Family First Physicians.

---------- ----------

Responsible Party Signature Print Patient Name

---------- ----------

Print Financial Responsible Name Date