**DR. ROBIN BAILEY’S**

**PRIVATE PRACTICE FINANCIAL POLICY AGREEMENT**

**Required Proof of Insurance**

I am responsible to present my Insurance card at EVERY VISIT. Dr. Bailey cannot bill my Insurance without verifying current insurance coverage. If I do not have my insurance card at the time of service, my appointment may need to be rescheduled.

**Notification of Change in Insurance**

I understand that I am responsible to notify Dr. Bailey of any changes in my Insurance before my appointment. If a claim is rejected because my insurance has lapsed, I am responsible for payment.

**Responsibility for Payment**

I acknowledge that acceptance of my Insurance information is not a guarantee of payment by my health plan until the claim has been accepted and processed. I further understand that if my claim is not accepted for payment, I am personally responsible for payment of medical services rendered to me.

**Responsibility of Co-Payments**

I agree to pay all applicable health plan co-payments at the time of service. I understand that if I do not pay my co-pay at the time of service, a $10.00 processing fee will be added to my bill.

**Non-Covered Services**

I understand that there may be services that are not covered by my Insurance and that I am responsible for payment of those services. Services may include but are not limited to: Telephone calls greater than 10 minutes; Completion of forms or reports; or Laboratory tests. I understand that I should check with my plan as to what services are covered.

**Delinquent Accounts**

I understand that Dr. Bailey may assign delinquent accounts to a Collection Agency.

**No Insurance Coverage**

If I do not have Insurance coverage on the date of service, payment in full is due at the time of service.

**Methods of Payment**

Dr. Bailey accepts the following forms of payments: Cash, Check, MasterCard, Visa, and Health Savings Account Credit Cards. I understand that a $20.00 service charge will be added for any retuned checks, PLUS the amount for the original check. Payments can be made by telephone during office hours. I understand that a $10.00 billing fee will be added to my account for every month that no payments are made on my account balance.

**Cases of Divorce**

I understand that Dr. Bailey will not mediate for payments due for dependents in any cases of divorce. In the case of joint custody, whoever brings the child to the appointment is responsible for payment at the time of service, even if the other parent is legally responsible. Repayment arrangements will be made between the divorced parents, not involving Dr. Bailey.

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Dr. Bailey agrees to work with each patient to resolve outstanding balances. Whenever I have financial hardship, I can discuss making payment arrangements with Dr. Bailey to keep my account in good standing.

A copy of this billing policy is available upon request.

**PATIENT OR AURTHORIZED PERSON’S SIGNATURE**

I acknowledge that I have read the above Financial Policy of Dr. Bailey and will abide by them. I further authorize the release of any medical or other information necessary to process any claims.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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