Community Medical
520 West Main Street, Marshville, NC 28103
704-624-3388 phone, 704-624-3390 fax

PATIENT FINANCIAL POLICY

If you have any questions about the policy, please discuss them with our staff. We are dedicated to provide the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

●As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor, in other words you agree to have your insurance pay the doctor directly. If your insurance company does not pay the practice within a reasonable length of time, (within 45 days) you may be responsible.

●Your insurance policy is a contract between you and your insurance company, the doctor is not involved.

●We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service. We must collect the co-payment at the time of the service per these contracts.

●If you fail to notify us of an insurance change, you are fully responsible for any amount not paid by your insurance company.

●If you have insurance coverage with a plan that we do not have a prior agreement we can still see you and you can file these charges with your insurance for coverage back to you. They will not pay us or take our filing, so our charges for your care and treatment are due at the time of service.

●Unless either you or your health coverage carrier have made other arrangements in advance, full payment is due at the time of service. For your convenience, we will accept VISA and MasterCard.

●All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge.

●For all services provided by our providers, we will bill your health plan. Any balance due is your responsibility.

●For all services rendered to minor patients, we will hold the parent or guardian accompanying the minor responsible for expenses incurred.

●To provide the best possible service and availability to all our patients, please call us as early as possible if you know you need to reschedule your appointment. There is a late cancellation fee of $25.00 if you do not cancel or reschedule your appointment within 24 hours.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I hereby state that I have listed ALL the MEDICAL INSURANCE COVERAGE that is current and I'm not aware of any other insurance(s). Otherwise, I am responsible for any claims not paid because of not informing this clinic of all medical coverages.

_____
Patient Signature

_____
Please print name Today's Date