Apple A Day Family Medicine
FINANCIAL POLICY

Patients with Insurance and Medicare

- Please provide a copy of your insurance card at the time of your examination. We must verify the numbers and address on your card in order to bill your insurance properly. If this is your first visit, we will also need a government issued Photo ID.

- **Please be prepared to pay your co-pay at each visit at the time of registration**. This is a part of your agreement with your insurance company, and we are contractually required by your insurance company to collect the co-pay (if one is due) upon receipt of services.

- You are responsible to pay any additional amount owed as directed by your insurance carrier within thirty(30) days of the date of your first statement from us. **All balances over 30 days will be assessed interest at the rate of 9% APR or 1% monthly. Balances past due by 30 days will be subject to late fee of $50.00. Balances past due by 60 days will be subject to an additional late fee of $100.00. Balances past due by 90 days will be subject to an additional late fee of $150.00. Balances past due by 120 days will be subject to an additional late fee of $200.00. _____ Initial.**

- If you feel that your insurance company has processed your claim incorrectly, please let us know. We can send an insurance claim to be reviewed to ensure charges were billed correctly.

Medicaid Patients

- For Washington Medicaid patients, we are contracted with “Healthy Options” plans Amerigroup, Coordinated Care, and UnitedHealthcare. We do not accept Idaho Medicaid.

Patients with no insurance or without proof of insurance

- Payment is expected when services are rendered unless other arrangements have been made in advance. We do offer a 20% discount when you pay at the time of service.

Worker's Compensation Claim

- If you are seeing our provider for an injury that occurred during the course of your employment, please be sure to notify the front desk that your injury is “work-related” so we can provide you with the correct paperwork. We have the paperwork for the State of Washington Labor & Industries in our office. If your employer is self-insured with another carrier, please bring the appropriate paperwork with you. If your employer or their insurance carrier denies the claim, we may appeal the decision for you. If the appeal is denied, we will bill your regular health insurance. You will be responsible for your deductible, copay, co-insurance, etc. We are contracted with WA Department of Labor &

Industries and the Idaho State Insurance Fund. If your employer is not covered by either of these carriers, please check with them in regards to any restrictions in who you may see for your claim.

Credit or Debit Cards

- We accept cash, check, and all major credit cards including Visa, MasterCard, Debit Card, American Express and Discover for payment on your account. There will be a $50.00 fee for all returned checks.

No Show Policy

- If you do not show up for your appointment, we assess a $25.00 “no show” fee. If you need to re-schedule your appointment, you must do so at least 24 hours prior to your appointment to avoid the “no show” fee.

If you are having difficulty paying your bill, we will make every effort to help you find a solution. However, if any balance remains on your account after 120 days, and payment arrangements have not been made with our billing department, your account may be turned over to our collections conditionality fees may apply. Office policy states that if your account is in collection status you will be at risk of being discharged from our practice.

I read and understand the information above. If bills remain unpaid without previous payment arrangements, Apple A Day Family Medicine may initiate collection procedures and/or legal actions, which will necessitate the release of confidential information for dates and types of services rendered. I agree to reimburse Apple A Day Family Medicine the fees of any collection agency, which may be based on a percentage at the maximum of 40% of the debt, and all costs, expenses, including reasonable attorneys' fees, we incur in such collection effort. I hereby release Apple A Day Family Medicine from all liability arising therefrom.

I understand that I am financially responsible for all charges whether or not paid by my insurance company. I, the undersigned, authorize treatment and request payment of authorized Medicare and Medicaid services and/or other insurance benefits be made payable to Apple A Day Family Medicine for any services furnished to me or my depends by Apple A Day Family Medicine. I authorize the holder of medical information about my depends or me to release the Centers for Medicare & Medicaid Services (CMS), its agents, and/or my current insurance company or any subsequent insurance companies from which I obtain coverage, any information needed to determine these benefits or the benefits payable for related services. If “other health insurance” is indicated, my signature authorizes release of information to the insurer or agency shown.

Patients Name: _____ Date of Birth: _____ Relationship to Patient:_____

Signature: _____ Date:_____
(Patient, Parent, Guardian, or legally authorized signature)

Printed name if signed on behalf of the patient:_____