Financial Policy

Thank you for choosing us for your care. We are committed to providing quality and affordable health care.

\_\_\_\_\_\_I have received this financial policy and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account.

\_\_\_\_\_\_I understand that delinquent accounts will be referred to a collection service; I agree to pay for all costs and expenses, including reasonable attorney fees.

\_\_\_\_\_\_I also acknowledge that I have received a copy of this financial agreement for my records.

• Our fees are representative of the usual and customary charges for our area.

• Charges for minor children will be billed to the parent with whom the child resides. We will bill appropriate insurance if all required information is provided. We will not bill or contact a non-custodial parent on behalf of the custodial parent.

• Dependents age 18 and older will be placed on their own account.

• If you believe your services are covered by another party and supply all required billing information, we will send the claim in for you as a courtesy, however, you remain responsible for payment.

• We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Billing your insurance is a courtesy service we provide for you but if the insurance information is not accurate, not in effect or declined by your insurance provider, you will be responsible for payment in full.

• Your insurance coverage is a contract between you and the insurance company. It is your responsibility to know your insurance benefits.

• We participate in many health insurance plans. If we participate in your health insurance plan, our fees are subject to a contracted fee schedule. It is your responsibility to verify participation prior to service. Participation may change at any time.

• If your insurance company has not paid within 60 days of service, the payment will become your responsibility. It is your responsibility to contact your insurance company regarding a disputed insurance claim.

• We will not bill a 3rd party.

• It is your responsibility to notify us of any changes in insurance coverage.

• Co-payments, co-insurance and charges that apply to your deductible are due at time of service.

• We accept payment by cash, check, VISA, Mastercard, Discover, and American Express

• You will receive a monthly statement listing all services, payments and adjustments, and noting the date your insurance was billed. The statement will specify an amount due from you, and payment is due upon receipt.

Delinquent Payments:

* If you do not pay the patient portion of your bil within 90 daysl, your account will be turned over to our collection agency, which may affect your credit rating.
* If we refer your account to a collection agency, you will be charged for all costs and expenses including a collection fee, and any reasonable attorney fees.
* Referral to a collection agency may result in dismissal from our practice or refusal of care.
* There is a $30 fee for all NSF checks.
* Refunds: After your insurance has processed your claim and if a refund is owed to you, we will process your refund within 30 days.
* Services from other Providers:
	+ You may have additional medical services ordered by your Provider, such as laboratory or pathology tests, x-rays or other radiology tests. Our clinic may draw blood, or take a sample, and send it to another company. You will receive a separate bill from that office for their services. You must make your own arrangements for payment with companies outside our office.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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