ASSOCIATED FAMILY PHYSICIANS

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Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans. If you are not insured by a plan that we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but do not have an up-to-date insurance card, payment in full is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles.** All co-payments must be paid at time of service. We will collect $75.00 on all PPO plans each visit until the deductible is satisfied. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your obligated co-payments and deductibles at each visit.

3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. **Proof of Insurance.** We must obtain a copy of your driver's license and current valid insurance to provide proof of coverage. If you fail to provide us with the correct insurance information, you may be responsible for the balance of the claim.

5. **Claim submission.** We will submit and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

6. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

7. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

8. **Nonpayment.** If your account is over 45 days past due, you will receive a final notice letter stating that you have 15 days to pay your account in full. We do offer a payment plan agreement providing you contact our business office upon receipt of your 30-day statement and meet the terms of sixty days to satisfy your balance. Please be aware that if the balance remains unpaid, we will refer your account to our collection agency and your immediate family members may be discharged from the practice. If this is to occur, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30-day period, our practices will only be able to treat you on an emergency basis.

9. **Missed appointments.** Our policy is to charge for missed appointment not cancelled within a two-hour reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

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Signature of patient or responsible party/Date