MAITLAND FAMILY PRACTICE

Patient's Name _____ Account Number _____

FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

Unless other arrangements have been made in advance by either you or your health coverage carrier, full payment is due at the time of service.

YOUR INSURANCE

We have made prior arrangements with many insurers and other health plans. We will bill those plans with which we have an agreement and will collect any required copayment at the time of service. We do not bill for copayments. In the event your health plan determines a services to be "not covered," you will be responsible for the complete charge. In that event, we will bill you, and payment is due upon receipt of that statement.

As insurance carriers tend to change frequently, it is the policyholder's responsibility to determine that we are contracted providers before being seen. You must bring your insurance card on your first visit as well as at any time your insurance coverage changes. We can not be held responsible for changes regarding your policy without a copy of the card for each insured.

If you have insurance coverage with a plan with which we do not have a prior agreement, we will be happy to prepare a claim for you. However, you will be required to pay for the complete charge at the time of service and your insurance company will reimburse you directly.

We will also bill your health plan for all services that we provide in the hospital or at a nursing facility. Any balance due is your responsibility and is due upon receipt of a statement from our office.

We do not bill secondary insurance. Medicare automatically bills Medicare crossover policies. If your policy is not a Medicare crossover, you are responsible for the balance upon receipt of a statement from our office. You must file your own secondary and will be reimbursed directly. We have instruction available if you need assistance filing your secondary.

We do not bill third-party insurance or auto-insurance. If you have been injured in an auto accident, you must tell the front office staff when you check in. You will be responsible for payment at the time of service. If you are injured at work, you must tell the front office staff when you check in as well. Further, you must bring a copy of your first report of injury and provide all relevant workers compensation information. If your claim is denied, you are responsible for all fees immediately upon receipt of a statement from our office.

METHODS OF PAYMENT

We accept cash, checks. VISA, MasterCard and Discover. We do not accept post-dated checks, nor will we hold checks for any length of time. Payment arrangements may be made in advance of your appointment as necessary.

MINOR PATIENTS

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

INFORMATION CHANGES

You must advise us of any address or phone number changes. We can not be responsible for delinquent accounts due to lack of receipt of statements or other correspondence if we do not have a current or correct address and phone number on file. Notice are assumed to be acceptable if they are returned to us as unclaimed, forwarding order expired or otherwise undeliverable.

COLLECTION PROCEDURES

Members of our billing department are always available to help with payment arrangements or budge plans. Once made in writing, agreements are binding. Our collection procedure does not begin until at least 30 days after your insurance had paid their portion or, if you do not have insurance, your account balance has reached at least 30 days old. Failure to respond to repeated communications from our office may result in discharge from the practice and/or involvement of an outside collection agency. You will be responsible for any fees or interest charged in association with collection of your account.

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 authorize the release of any medical information necessary to process my insurance claim.

_____ _____

Signature of Patient of Responsible Party Date