MITCHELL FAMILY MEDICINE

Financial Policy

Effective 2-13-2020 **Patient Name:_____**

Thank you for choosing MITCHELL FAMILY MEDICINE as your health care provider. **Please carefully read and initial by each statement and sign below.** This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager or billing department will be glad to discuss these policies with you.

1._____ I understand that if **I do not have my insurance card**, referral, and / or co-payments, that my appointment may be rescheduled until such time that I can provide the required documents or payments.

2._____ I understand that MITCHELL FAMILY MEDICINE will collect all copayments at the time of visit and any deductibles and possible coinsurance amounts provided during insurance verification at the time of service. Payment in full and expected coinsurance payment responsibility are determined by the anticipated billing code(s), details of your insurance policy, and agreement between your insurance company and MITCHELL FAMILY MEDICINE. Any overpayment to your account will be refunded to you **at your request** after payment and/or remittance has been received from your insurance company.

3._____ I understand that a $25 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF MUST BE PAID WITH CASH OR CREDIT CARD and I will no longer be able to pay for any services by personal check.

4._____ I understand that if I am unable to make a SCHEDULED APPOINTMENT OR PROCEDURE, I need to contact MITCHELL FAMILY MEDICINE at least 24 hours before my scheduled appointment time. Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and may keep others in need of medical care from being seen. **A $25 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS**.

5._____ I understand that if my account is not paid in full within 90 days of a statement date, a 35% collection agency processing fee may be added to the outstanding balance and may be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

6._____ MITCHELL FAMILY MEDICINE will allow 60 days from the date of filing for my insurance company to process or pay a claim. State law allows insurance companies operating in the state no more than 60 days to process claims. It is my responsibility to provide my insurance company with requested information needed to process a claim for services. It is also my responsibility to notify MITCHELL FAMILY MEDICINE if there is any change in my insurance coverage, residence, or phone number. ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS**. I UNDERSTAND IT IS MY RESPONSIBILITY TO PROVIDE A CURRENT INSURANCE CARD TO BE SCANNED TO MY RECORD.**

7._____MITCHELL FAMILY MEDICINE may charge a fee to the patient for any additional forms including but not limited to FMLA paperwork.

I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by the provider.

Signature of Responsible Party:_____ Date:_____

ASSIGNMENT OF BENEFITS

We require insured patients to complete assignment of benefits authorizing insurance to remit payment to physician's office.

I hereby assign all medical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to: MITCHELL FAMILY MEDICINE. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges not paid or adjusted by provided insurance. I hereby authorize said assignee to release all medical information necessary to secure the payment.

Signature of Responsible Party:_____ Date:_____