# Financial Policy Statement

Thank you for choosing our physicians for your health care needs. We are committed to provide the very best medical care and treatment. The following is a statement of our Financial Policy, which you must read, agree to and sign, prior to treatment. Our financial Policy applies to all service rendered by our physicians and staff whether inpatient or outpatient.

**Practice Payment Policy Guidelines:**

- **Patients (guardians) are financially responsible for all charges, regardless to third-party involvement.**
- **Full payment is due at time of services, unless prior insurance billing arrangements have been made.**
- **Patients with insurance will be required to pay all "out-of-pocket" financial obligations at time of service.**
- **We accept: Cash, and the following credit cards: Visa/MasterCard/Discover.**

**Patient Responsibilities and Financial Policies:**

Provide accurate information: You have a responsibility to provide accurate complete information about your health history, mailing address, health insurance, and other billing information. If any information changes-name, address, phone insurance coverage, etc. –You must inform this practice immediately. Insurance denials or billing errors due to patient supplied information will result in the transfer of the account balance to the patient's immediate financial responsibility.

Know Your Insurance Coverage, Benefits, and Referral Requirements: Your health insurance is a contract between you and your health insurance plan(s). Patients are responsible for understanding their health insurance coverage(s), benefits and referral requirements to receive diagnostic and therapeutic services from our physicians. Patients are for securing the necessary written referrals, pre-authorizations or pre-certifications from your primary care physicians or health plan prior-to services rendered. If we have not received the necessary authorizations prior-to your appointment, the appointment will be rescheduled. Please present your Insurance ID card to our staff upon registration for each office visit.

Self-Pay Patients: Patients without insurance coverage are expected to for services received in full at time of service, unless a satisfactory payment agreement has been arranged with our billing manager prior-to services being rendered.

Patients with Private Insurance/Medicare/Medical Coverage: Our Physicians participate with the Medicare and Medicaid Programs, and with most major insurance companies. We will file claim(s) to your insurance provided you authorize the "assignment of benefits" below for payment directly to our practice. For participating insurance plans, the practice will accept payment based on contractual agreements. For plans that we do not participate (i.e., there is no contractual agreement), the practice will expect full payment from the patient at time of service. Any coverage or payment dispute is a matter between the insurance policyholder and the insurance company.

**Patient Payment Agreement:**

I understand that I am fully responsible for all charges regardless of third-party involvement. I agree to pay any deductable, coinsurance, co-payment, or services deemed as "non-covered" by my insurance carrier at the time of service. If my insurance has not paid on my account in 60 days, the outstanding services will become my responsibility for immediate payment (unless Medicare and Medicaid). Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, non-payment at time of service and/or any other reason; I agree to pay all charges within 30 days of notice. I understand that if I fail to pay outstanding balances or make payment arrangements within 75 days, the amount will be considered delinquent and subject to legal action. I further understand that delinquent accounts will be assessed a 1.5% interest charge per month (18% APR), and the possible dismissal of the patient from our care. If my account is forced to "collections", I agree to pay all collection costs, including, but limited to, court costs attorneys fees equal to 33.33% of the amount owed, and accrued interest charges to date. I agree to pay a $50.00 fee for each missed appointment not cancelled at least 24 hours in advance. Copies of my medical records can be obtained with advanced notice in accordance with §8.01-413 of the Code of Virginia, with charges not to exceed $0.50 per page and for the first 50 pages and $0.25 per page thereafter, in addition to a $10.00 handling fee plus postage expense. The completion of special forms or reports has a charge of $50.00.

**Authorization & Assessment of Insurance Benefits:**

I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of specific medical or other protected health information, whether manual, electronic or telephonic. I authorize the Practice to apply benefits for services rendered to myself or minor child under any health insurance policies providing benefits and do hereby also assign and authorize payment of benefits from my insurance company to the Practice (including benefits payable under Title XVIII of the Social Security Act and/or any other governmental agency.) I irrevocably authorize all such payments to the Practice. I authorize the Practice to contact the employer or insurance company regarding insurance information, existence of insurance and coverage of my benefits.

**Medication Agreement:**

As a patient of Valley Family and Procedural Medicine/Allure Medical, I give authorization to view previous medications electronically and I agree to have all my medications electronically submitted for pick up at my pharmacy.

**In consideration for medical services rendered, I acknowledge receiving notice of the financial policy and agree to pay for said medical services according to the above terms. My signature below indicates that I have read and agreed to the above policy.**

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**(Patient/Responsible Party/Guardian Signature)** **(Date)**