Financial Statement and Policies for the Family Care Clinic

Below you will find a list of financial policies for the Family Care Clinic. Please read and sign this statement to affirm that you have read, understand, and agree to these policies.

1. Please bring your insurance card with you to every visit. If you do not have an insurance card, we will treat you as a cash patient.
2. Patient balances must be paid in full before seeing the doctor or receiving prescription refills.
3. Co-pay is due at check-in.
4. Please review what your insurance covers so you understand whether or not you will be responsible for labs and/or procedures.
5. A $25.00 cancellation fee will be applied if an appointment is not cancelled within 24 hours of the scheduled time.
6. Refills will not be authorized after regular office hours.
7. Patient responsibility balances must be paid in full before seeing the doctor.
8. No checks will be accepted on the first visit. Please pay with cash or a credit card.
9. A $25 NSF fee will be applied to any returned checks.
10. If your insurance company, including Medicare, does not pay for a service, procedure, labs, or injections, you will be responsible for that balance regardless of whether or not your insurance company has transferred this balance to your responsibility.
11. There will be a $25 late fee applied to any balances after 30 days from the date of the first notice. If we have to send your bill to a collection agency, a $35 fee will apply.
12. There will be a $10.00 charge to replace lost prescriptions or if they need to be re-written because they have expired. (Prescriptions for controlled substances must be filled in 21 days by law).
13. There is a charge for any papers or forms dropped of that need to be filled out by a Provider.
14. A deposit is required for all new patient appointments in the amount of their copay or deductible according to your plan. This is non-refundable if the appointment is not kept or cancelled.
15. You will be released from the practice if you have excessive No Shows or Cancelled appointments.

I have read, understood, and agree to adhere to the policies of the Family Care Clinic.

_____ _____

Signed Date