

FINANCIAL POLICY **SUMMIT FAMILY PRACTICE**

Our goal is to provide you excellent medical care in a comfortable, personal and cost effective manner. Our financial policies have been developed to help keep the cost of “doing medicine” down, which means lower fees for you. You can help by paying for your care in a timely manner. Thanks!

Payment at the time of service is expected.

Payments to Summit Family Practice may be made by cash, check, Visa or Mastercard. Patients who are here for their first visit are expected to pay in full unless prior arrangements have been made with the billing department. We do our best to include all charges at the time of service. Occasionally, charges may be added or modified after your visit. For example: an additional blood or urine test may be ordered by your clinician or the level of service may be modified per AMA guidelines by your clinician.

Insurance billing

Insurance billing is a **courtesy** to our patients whose accounts are in good standing. Once you have met your annual deductible, we will bill your insurance company. You are expected to pay your **co-payment** and for any **non-covered services** at the time of your visit. **We expect payment in full within 60 days for services billed to insurance.** It is your responsibility to pay any balance older than 60 days and to follow up with your insurance company for reimbursement. If we receive a payment from your insurance company after your balance has been paid, we will issue you a refund. It is your responsibility to contact your insurance company if a claim is denied, paid at a lower rate than you expected or if it has not been paid within 60 days. If we have made an error we will gladly resubmit a corrected claim.

Overdue Accounts

We reserve the right to charge a fee for overdue accounts and for submitting insurance forms after 60 days. If you need ongoing medical care, we expect payment on your old balance as well as payment in full for new charges at the time of service. Accounts with balances **over 90 days** will be turned over to a professional collection agency unless you are making timely payments on an approved payment plan. Once an account has been referred for collection, the doctor-patient relationship is considered terminated and your records will be referred to a physician of your choice.

No Show and Cancelled Appointments

We reserve the right to charge a fee for “**no show**” and **appointments canceled with less than 24 hours notice**. Our policy states: *Please call ahead if you are unable to keep an appointment. 24 hours notice is required. We reserve the right to charge a fee for appointments that are missed or that are cancelled with less than 24 hours notice. If two appointments are missed or three appointments are cancelled without prior notice, patients will be discharged from services.*

Cancelled appointments	1 st time:	Warning-no charge
	2 nd time:	\$45.00 to \$75.00 charge
	3 rd time	Discharge from clinic
No Show	1 st time	Warning -\$45.00 to \$75.00 charge
	2 nd time	Discharge from clinic

FINANCIAL AGREEMENT

- I agree to pay promptly all fees and charges for treatments provided to me and/or my family.
- I have read the policies above and understand them.
- All insurance payments for services rendered are assigned to this office. (A copy of this assignment is as valid as the original).
- I understand that it is my responsibility to contact my insurance company should a claim be denied or not paid in full.
- I promise that I will pay all charges in full within 60 days, even if insurance payment is expected.
- I understand that charges may occasionally be added or modified by my clinician.
- I understand that I am financially responsible for all charges, whether or not they are covered by my insurance.
- I authorize this clinic to release to my insurance carrier any medical information needed to obtain payment for services rendered.
- I understand that if I disagree with any charges, I will contact this office in writing within 30 days of the billing date.
- Should legal action be taken by this office to collect an unpaid balance due for medical services provided, I/we agree to pay reasonable attorney’s fees or other such costs as the Court determines proper.

NOTICE: Do not sign this agreement before you read and agree to the conditions set forth above. You should keep a copy of this agreement in your records.

Signature: _____
Responsible party

Date: _____