

FINANCIAL POLICY

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.

Patient Name: _____ Account No.: _____

ASSUMPTION OF RESPONSIBILITY

Payments to Summit Family Practice, LLC may be made by cash, check, Visa or MasterCard. Patients 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 but occasionally, charges may be added or modified after the visit. (For example: an additional blood or urine test may be ordered or the level of service may be modified per AMA guidelines).

Summit Family Practice reserves the right to charge a fee for delinquent accounts and for submitting insurance forms after sixty (60) days. If ongoing medical care is needed, you are expected to pay on your old balance as well as payment in full for new charges at the time of service. Accounts with balances over ninety (90) days may be turned over to a professional collection agency unless you are making monthly payments on an approved payment plan. Once an account is referred for collections, the doctor/patient relationship is considered terminated and your records will be referred to a provider of your choice.

By signature below, I/we, whether signing as guarantor or as patient, understand and hereby agree that in consideration of services to be rendered to the patient named above, assume the obligation, the financial responsibility and agree to pay upon demand to **Summit Family Practice, LLC** all fees for such services and incidentals incurred by named patient. Should the account be referred to an attorney for collection or to a collection agency, the undersigned shall pay reasonable attorney fees, collection fees and other expenses as a court may determine proper.

By signature below, I/we understand that in connection with collection procedures **Summit Family Practice, LLC** has the right to request, receive and review all credit information as provided by a licensed and duly operated credit bureau.

By signature below, the undersigned understands that all bills are payable upon presentation and that the guarantor and **NOT** the insurance is responsible for the payment of all services. If the undersigned disagrees with any charges, they will contact this office in writing within thirty (30) days of the billing date.

ASSIGNMENT OF INSURANCE BENEFITS

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

By signature below, I/we hereby guarantee payment of all charges as outlined above and incurred for the account of the above named patient from the date of first treatment until final date of discharge or termination of treatment.

By signature below, I/we hereby assign direct payment of any hospital insurance benefits, medical insurance benefits (including major medical benefits, insurance sick benefits or injury benefits) payable because of the liability of a third party or organization, and so forth, payable to or for the above named patient be paid in full.

NO SHOW AND CANCELLED APPOINTMENTS

Summit Family Practice reserves the right to charge a fee for "no show" and "cancelled" appointments with less than a 24 hours notice. Our policy requires: (1) receiving a 24-hour notice if the patient is unable to keep an appointment; (2) applying a fee for missed or cancelled appointments with less than a 24-hour notice; and, (3) discharging a patient when two appointments are missed or three appointments are cancelled without prior notice. New patients failing to keep their first appointment without a 24-hour notice will not be granted another opportunity for an appointment.

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 appointments	1 st time:	Warning and/or \$45 to \$75.00 charge	2 nd time:	Discharge from clinic		

AUTHORIZATION TO RELEASE INFORMATION

The undersigned hereby authorizes said **Summit Family Practice LLC** to release sociological and medical information officially acquired in the course of examination and treatment for the purpose of filing for insurance benefits and other financial coverage.

This authorization to release information shall remain in place until all claims have been paid.

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

BY SIGNATURE BELOW I ACKNOWLEDGE THAT I HAVE READ, I UNDERSTAND AND I APPROVE ALL OF THE ABOVE.

Signature: _____ Date: _____
Signature of Patient, (Guarantor, if patient is a minor or unable to sign)