THREE TREE INTERNAL MEDICINE FINANCIAL POLICY

OUR PRACTICE FINANCIAL POLICY:

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our Billing Manager. We are dedicated to providing the best possible care and service to you, and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either yourself or your health coverage carrier, full payment is due at time of service. For your convenience, we accept major credit cards, or a payment schedule can be arranged.

Balance is due upon receipt of a statement from our office. Accounts over 60 (sixty) days past due will be subject to interest charge of 1% per month on the unpaid balance.

YOUR INSURANCE:

We have made prior arrangements with many insurers and health plans including Medicare to accept assignment of benefits. We will bill those plans with whom we have an agreement and will only require you to pay the assigned co-payment at the time of service. **If you do not pay your co-payment at time of service, you will be charged for sending a statement.**

If you have insurance coverage with a plan that we are not contracted with, and you provide us with identification and group numbers and a claims address, we will bill them directly as a courtesy to you.

In the event your health plan determines a service to be "not covered", you will be responsible for the balance. Payment is due upon receipt of a statement from our office.

We will bill your health plan for services we provide in the hospital. Any balance due is your responsibility and due upon receipt of a statement from our office.

MINOR PATIENTS:

For services rendered to patients who are minors, we will look to the adult accompanying the patient and the custodial parent or guardian for payment.

MISSED APPOINTMENTS:

In order to provide the best possible service and availability to all our patients, we request 24 hour advance notice to cancel or reschedule your appointment. **We reserve the right to charge for insufficient notice of reschedule or cancellation, or failing to keep an appointment.**

I have read and understand the financial policy of the practice and I agree to abide by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

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Signature of Patient or Responsible Party if Minor Date

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Please PRINT Patient Name