# Patient Financial Agreement

## PATIENT INFORMATION

**Deductible/Co-Insurance:** All applicable co-insurance and deductibles are due at the time of service. An estimate will be provided and payment is required before services are rendered. This does not constitute final payment and any additional balance due after the insurance claim is adjudicated will be due upon receipt of a bill. **Initials** _____

**Co-Payments:** Your insurance company requires us to collect co-payments at the time of service. Due to state and federal laws, co-payments will not be waived. **Initials** ____

**Checks:** Returned checks may be subject to a $30.00 fee. **Initials** ____

**Cash Pay Patients:** The amounts you pay for today's scheduled office visit may not be your final payment. Other costs that may be accrued for today's appointment are including, but not limited to, laboratory tests, X-ray tests, any injections, special procedures or additional office visit charges. **Initials** ____

**Claims Submission:** As a courtesy, Arch Health Medical Group will bill your insurance. A quote of benefits is not a guarantee of payment. We will submit your claims and assist you until claim is resolved. Payment from your insurance company is expected within 45 days. After 45 days, we will look to you for full payment. You are responsible for all non-covered services according to your insurance company's guidelines. If we receive notification that you are not eligible for coverage or we are not contracted with your insurance, you will be responsible for all charges incurred and payment is due upon receipt of the bill. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request in a timely manner. You are responsible to provide a copy of your most recent insurance cards for all applicable health plans. Accounts that are 90 days past due may be referred to a collection agency. **Initials** ____

**Preventative Care Services:** Routine exams may be covered by your insurance. When a medical concern is addressed at the time of your visit, preventative benefits will no longer apply. Additional fees may incur including but not limited to co-pays, deductibles and co-insurance. **Initials** ____

**Ancillary Services:** Laboratory and outpatient radiology procedures will be billed separately by an outside provider. Please contact them directly with any questions regarding your bill. **Initials** ____

**Assignment of Benefits:** Authorization is hereby granted to release information as may be necessary (in compliance with HIPAA guidelines) to process and complete my insurance claim and payment of medical benefit is to be paid directly to Arch Health Medical Group for all services rendered. **Initials** ____

**Missed Appointments:** Please note a $25.00 cancellation fee will apply for missed appointments or failure to cancel within 24 hours prior to your scheduled appointment time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

If at any time you should experience financial hardship and need to make special payment plan arrangements, please contact our billing office.

I have read and understand the above statements. I**nitials** ____

I agree to comply with the financial policies of Arch Health Medical Group and, I understand that I am financially responsible for payment of all medical services or treatment(s) administered with my account.

_____ _____

Patient / Guardian Signature Date

_____ _____

Patient Name (Please print) Date of Birth