WELCOME TO FOOTHILLS FAMILY MEDICINE

Please take the time to **READ, SIGN, AND DATE** this financial policies form. If you feel that you need additional information or explanation regarding these policies, please refer to our **office brochure**, and our billing specialist will be glad to answer any questions.

We are contracted with many insurance plans. Under these plans the patient or responsible party may be required to pay deductible, co-pay, co-insurance for non-covered goods and services. **COPAYS AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE or your appointment may be rescheduled!**

We accept **VISA and MASTER cards.** We also accept **MONEY ORDERS**, **CASHIER CHECKS** and **CASH**. We **DO NOT** accept PERSONAL CHECKS.

It is **YOUR RESPONSIBILTY** to know your insurance plan benefits. **ROUTINE PHYSICALS, IMMUNIZATIONS, WELL-CHILD CHECKS, certain LABORATORY TESTS, PROCEDURES, and PRESCRIBED MEDICATIONS, etc., may NOT BE COVERED.**

If a service is not covered by your plan, payment is due at time of service. We encourage you to contact your insurance carrier ahead of time and verify appropriate coverage. We will also require proof of insurance in the form of an insurance card, or in the case of a new policy a copy of the enrollment form specifying insurance company name and phone number, employer and his/her phone number, insured employee name, date of birth and social security number.

If we are not contracted with your insurance plan, **YOU** must pay in full at time of service. A copy of your driver's license will be taken. You will be given a copy of our charge slip to submit to your insurance for reimbursement purposes.

We submit our services to your insurance company as a courtesy to you. However, you are **RESPONSIBLE** for the balance of the account and any portion not paid for by your insurance, and you will receive a statement detailing the activity and balance on your account. You may need to contact your insurance carrier to find out why they have not made payment. Outstanding balances must be paid before scheduling another appointment.

Balances over **120 DAYS** due may be sent to a collection agency unless other arrangements have been made. A **$ 50** fee may be assessed on accounts placed in collections. If you require a payment plan, our office administrator will be glad to arrange this with you. A **$ 25** service fee will be charged for previously written returned checks due to insufficient funds.

If an appointment is missed without timely notice, a **$ 50** fee will be assessed to the account if a second No Show occurs.

There will be a **$50** charge for any letter written by our provider on behalf of a patient.

Please refer to our **office brochure** for additional information regarding our office policies.

Thank you for choosing our office for your healthcare needs.

I HAVE READ, AGREE, AND UNDERSTAND THE ABOVE POLICIES OF FOOTHILLS FAMILY MEDICINE, AND BY SIGNING BELOW I ACCEPT THESE RESPONSIBILITES:

________________________________Patient/Responsible Party ________________Date

________________________________Witness (Foothills Family Medicine) ________________Date