EAST VALLEY FAMILY MEDICAL FINANCIAL

POLICIES AND ARRANGEMENTS

We recognize the need for understanding the areas of payment arrangements and insurance filings. This sheet has been put together to address some of these areas for you.

- **INSURANCE, FILING/BENEFITS/PAYMENT**
  There are numerous insurance plans with which we have contracted to receive payment directly from the insurance company. With these plans, the patient is generally required to meet a deductible or make a co-payment. If you are covered by one of these plans, please show us your card. Be prepared to make your co-payment, or pay for your office visit if your deductible has not been met at the time of service. We accept cash, checks, Visa, and MasterCard. With plans that we are not contracted with, you will be asked to pay at the time service is rendered.
  If we are billing your insurance for you, it is extremely important that you furnish us with accurate and updated information so your claim can be filed. It is your responsibility as a consumer to know what benefits are covered by your insurance plan. Most insurance carriers have numerous plans that cover different types of services. Contraception (Depo-Provera), immunizations, and other services, may not be covered on your particular plan. Services provided that are not a covered benefit are your responsibility and payment is due at the time services are rendered. If you have questions as to what services are covered, contact member services (the number is listed on your insurance card). We will set aside the portion of the balance estimated to be paid by your insurance carrier for 45 days. If your carrier does not remit payment within 45 days, you will be responsible for the full balance. This office cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim, you will continue to receive statements until the account is paid in full.
- **PAYMENT ARRANGEMENTS**
  Payment is expected at the time of service. If you do not have your co-pay at the time of service, your visit may be rescheduled. Also, we recognize the need to set up payment plans for patients who require extensive treatment. Our business office will be happy to help you with these arrangements.
- **DELINQUENT ACCOUNTS**
  Bills that are delinquent for more than ninety (90) days will be transferred to an outside collection agency unless prior arrangements have been made. If you have questions or think an error has been made, please discuss them with us prior to the 90 days in order to help us resolve this.
- **RETURNED CHECKS**
  There is a $25.00 service fee for checks returned for insufficient funds. We belong to the Maricopa County Attorney's Check Enforcement Bureau. We request a copy of your driver's license or ID card as identification.
- **CANCELLATION OF APPOINTMENTS/ NO-SHOW APPOINTMENTS**
  If you cancel an appointment, we ask that you give us a 1-day notice for routine appointments and a 2-day notice for physicals and office surgeries. If you do not cancel an appointment, you can be charged $25.00 as this will be considered a no-show. Three no-show appointments are grounds for dismissal from the office.
- **ADVANCED BENEFICIARY AGREEMENT**
  Medicare and other insurance plans will only pay for services that they determine to be reasonable and necessary under section 1862 (a) (1) of Medicare Law. If payment is denied for services or tests, (i.e. routine exam/lab work, vaccinations, contraception, procedures, and non-related diagnoses for the services provided), then the patient is personally and fully responsible for payment.

ADDITIONAL HELP

Please feel free to discuss any concerns you may have with our office staff. Our staff is dedicated to making your visits with us as pleasant as possible. **It is your responsibility to know what is covered by your insurance plan as well as being financially responsible for any services denied or not covered by insurance.**

I have read and agree to the above policy of East Valley Family Medical. I understand the contents and by signing below accept the aforementioned financial responsibilities.

Patient/ Guardian's Signature_____ Date:_____