**Bash Family Practice Financial Policy
Effective February 1st 2017**

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable healthcare. Because some of our patient have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you have and sign in the space provided. A copy will be provided to you upon request.

1. **Non-payment.** All balances less than $200.00 must be paid in full in 90 days. If the balance is carried over 90 days, a $10.00 surcharge will be assessed each billing cycle. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid after 180 days, we will refer your account to a collection agency; and you will be discharged from this practice. If this occurs, you will be notified by regular mail that you have 30 days to find alternative medical care. During that 30-day period, our providers will only be able to treat you on an emergency basis.
2. **Missed appointments.** Our policy is to charge for missed appointments not cancelled 24 hours prior to appointment time. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment.
3. **Coverage changes.** If your insurance changes, please notify us before your next visit so that we can make the appropriate changes to help you receive maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will be automatically billed to you.
4. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured, payment in full is expected at each visit. If you are insured by a plan we do business with but don’t have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage, or you will be asked to reschedule your appointment. We must obtain a copy of your driver’s license and current valid insurance card to provide proof of insurance. Knowledge of your insurance benefits are your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
5. **Co-payments.** All co-payments must be paid at time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-pays and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
6. **Claims submission.** We will submit your claims and assist you in any way reasonable we can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

**All balances incurred prior to February 1st 2017 will be subject to the rules of this new policy effective February 1st 2017. Refusal or failure to comply with this agreement will result in dismissal from the practice. Our practice is fully committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy.**

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