

SALIDA FAMILY MEDICINE

POLICIES REGARDING FINANCES

Our request to ALL patients is that payment for medical services rendered shall be made at the time the services are provided. Co-pays must be collected at the time of service. There are some things YOUR insurance may not cover. Please be aware that **PHYSICALS, LABS and IMMUNIZATIONS, MEDICAL SUPPLIES, REPEAT PROCEDURES, i.e., PAP SMEARS, WHICH YOU RECEIVE during your visit, are your responsibility. At times the insurance will only pay a portion of some services. Our costs for these items must be redeemed from you the patient. YOU are responsible for all charges that are not covered by YOUR insurance.** Patients that have no insurance will be required to pay at time service. A 20% discount on the professional fee (immunizations, shots, supplies, tests, etc., are excluded) will be given to cash patients.

From time to time circumstances are such that payment is not made for medical services at the time they are rendered (i.e. hospital care, surgical operations, etc). On these occasions a statement is sent and any balance owed on the statement is due and payable, in full, upon receipt of that statement. Our statements are issued monthly. Once again, we appreciate payment, in full, of any outstanding balances. On occasion, the amount of medical charges is large enough that patients are unable to pay the entire amount at the time of receipt of the statement or at the time services are provided. We feel that a **MINIMUM** acceptable amount is \$25 per month for balances under \$200 and 10% of the balance per month for any balances over \$200. We currently do not charge interest on accounts which are overdue or which are not paid in full. In exchange, we hope that our patients will not abuse this privilege of credit that we have extended to them. Nonpayment of your account could result in you being discharged from this practice.

Questions from our patients regarding charges for medical services, which are unexplained or seem unwarranted, should be discussed with our billing department.

Signature _____

Printed Name _____

Date _____