

Patient Responsibilities Notification

We will submit all charges to all insurance (primary, secondary, etc.) as a courtesy to you. However, we do require payment at the time of service for all co-payments, deductibles, and co-insurance. We cannot bill your insurance unless you bring all current insurance information with you. It is your responsibility to provide us with complete and accurate information at EACH office visit. Failure to do so will result in the patient incurring complete and total financial responsibility for all charges. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some services provided may be "non-covered" under the terms of your contract and, therefore, not paid by insurance. You are responsible for the payment of your deductible and co-pay if there is no secondary insurance. Copies of your information will be made for our files.

It is the patient's responsibility to inform us of any special requirements or specific facilities associated with your benefit plan. If we inadvertently order services, such as lab work, diagnostic tests, etc. that are not covered or ordered at an out of network facility, we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.

All patients are expected to provide their insurance card at the time of check in at each visit. All patients are responsible for making sure they know what benefits are included under their insurance plan and ensure they are following all regulations/ rules defined in their plan.

A deposit will be required for all patients that do not have insurance coverage prior to seeing the provider. Payment in full is expected at the time of service unless billing arrangements have been made by our billing staff PRIOR to the visit.

Adult Patients: Adult patients are responsible for full payment of their accounts.

Minor Patients: Patients under the age of 18 years will not be seen unless accompanied by a guardian or a signed authorization from that guardian allowing our physicians to provide medical treatment. The adult, parent or guardian accompanying a minor will be responsible for full payment of the account.

There is a \$50.00 form fee for any forms presented to the office for completion not presented during a regular visit. Examples include: Disability, Adoption forms, Insurance claim forms, etc.

Payment in full or payment arrangements can be made on any outstanding balance. No payment activity within 120 days from the date of service will result in the account being turned over to an outside collection agency. The patient will be responsible for all collection fees, cost, interest, and/or attorney fees and will be applied to the outstanding balance.

Any account that has been turned over to a collection agency **MUST** be paid fully before any treatment is rendered. Failure to meet your financial responsibilities may result in discharge from the practice.

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the primary care provider. I understand if there are any changes in my insurance coverage, I will notify my primary care provider immediately. I hereby give consent for treatment of myself or my child to the primary care provider at Christian Family Medicine.

I understand that Christian Family Medicine, Inc. is a PCMH facility and I have been given information to explain the program.

I understand that I have been made aware of CFM&P Notice of Privacy Practices.

I request payment of authorized Insurance/Medicare benefits be paid to Christian Family Medicine, Inc. on my behalf. I authorize any holder of medical information about me to release to the Healthcare Financing Administration, any information needed to determine these benefits. I understand my signature authorizes the physician to furnish information to insurance carrier concerning my illness necessary to pay my medical claims and I hereby irrevocably assign payments to Christian Family Medicine, Inc. I understand I am financially responsible for all charges, whether or not covered by insurance. I also understand my medical records may not be released if I am not financially in good standing with Christian Family Medicine, Inc. A copy of this authorization shall be considered as valid as the original.

Signature of Patient or Responsible Party (state relationship)

Date