ROCKDALE FAMILY PRACTICE, P.C.

Financial Policy

Full payment is due ***at the time of service***, including all deductibles, coinsurance, copays, and past balances. If your insurance carrier considers any service a non-covered service, or if you are paid directly by your insurance carrier, payment will be expected in full at the time of service. All payment arrangements must be ***prior*** approved by the Practice Administrator and/or Billing Department Supervisor. Payment arrangements will only cover the specific charges and dates of service agreed upon. They will not cover additional charges or dates of service. We accept cash, check, money orders, VISA, MasterCard, and American Express. Our practice is committed to providing the best treatment for our patients and we charge what is usual, customary, and reasonable for the geographic areas we cover. All checks submitted to our office will be processed through ***Telecheck*** in order to verify availability of funds. Should your check be returned by the bank due to insufficient funds, you will be assessed a returned check fee of $30.00.

Our office will file your claims to your insurance carrier(s) as a courtesy to you. Your insurance coverage is a contract between you and your insurance carrier. Your entire account balance, including charges filed to your insurance company, ***is your responsibility.*** You are responsible for follow-up communication with your insurance company should there be any problems in processing a claim. It is your responsibility to know your plan benefits. You are financially responsible for all copays, coinsurance, and deductibles required by your insurance carrier. Please be aware that some, or perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under federal programs, commercial insurance plans or self-insured plans. ***You will be held responsible for these services.***

Monthly statements will be sent to the patient for any balance for which the patient is responsible. If a balance remains after 120 days, the account will be forwarded to a collection agency.

There will be a $25 fee charges for all missed appointments and/or no shows. A missed appointment is considered as such if you fail to contact our office and give a 24-hour notice of canceling an appointment, or you fail to show for your scheduled appointment. ***These missed appointment fees will not be covered by your insurance carrier and will be billed directly to you.*** You will not be charges a missed appointment fee if our office cancels or reschedules your appointment.

For diagnostic testing, if you must reschedule, we require a 24-hour notice. If you cancel or miss your appointment without the required 24-hour notice, we will assess a $50 cancellation/no show fee. ***These missed appointment fees will not be covered by your insurance carrier and will be billed directly to you.*** You will not be charged a missed appointment fee if our office cancels or reschedules your appointment.

You are asked to confirm your demographic and insurance information at every visit. Should you provide us with incorrect information, our office will charge a $25 misinformation fee for each visit that incorrect information is provided. ***This fee will not be covered by your insurance carrier and will be billed directly to you.***

_____ _____

Signature of Patient or Responsible Party ***Date***

_____ _____

Print Patient Name ***RFP Patient #***