Rockdale Family Practice, PC
Financial Policy and Payment Authorization Form

1. I am ultimately responsible for payment of charges for services I receive from this practice including those covered by my insurance. As a convenience, this practice will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.

2. Some immediate payment may be expected at the time of service. This may include a co-pay and additional payment if this practice determines that the cost of my visit today will not be reimbursed by my insurance provider. This often happens if my deductible is not yet satisfied. As a self-pay patient, the office visit fee will be paid before my visit and the remainder at check-out.

3. This practice may deny service or charge a service fee for failure to pay a co-pay at the time of service.

4. It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit.

5. I agree to provide the above practice and/or its designated payment agent with my debit/credit card or ACH information.

6. The applicable payment card or ACH information will be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information. Card or ACH Information will be obtained through a card swipe, manual entry from card, void check, or verbally in person or over the phone.

7. I authorize the above practice and/or its designated payment agent (with my written and/or verbal authorization) to apply charges to my payment card and/or ACH account for all amounts owed to the practice for medical visits, procedures or supplies, including (i) amounts agreed as part of a payment plan, (ii) copayments, (iii) coinsurance (after application of insurance proceeds), (iv) amounts not covered by insurance and/or (v) fees ($25.00 for clinical appointments and $50.00 for physical appointments and diagnostic testing) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation. A missed appointment is considered as such if I fail to contact the office and give a 24 hour notice of cancelling an appointment, or if I fail to show for my scheduled appointment. Should my check/ACH payment be returned by the bank for insufficient funds, I agree to pay a returned check fee of $30.00.

8. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly statement for any outstanding balance.

9. Transaction receipts will be maintained in the patient file or will be emailed to me if I provide and maintain a valid email address.

10. I authorize the above practice and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement if I choose to opt-in for eStatements. ***Please note: eStatements will be sent from "Patient Notebook", our statement vendor.***

11. If a balance remains after 120 days, my account will be forwarded to an outside collection agency. Placement with an outside agency may cause termination of my care with the practice. According to the Telephone Consumer Protection Act (TCPA) by the Federal Communications Commission, I agree, in order for the practice to service my account or to collect monies I may owe, Rockdale Family Practice, PC, and/or our agents may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. You may also contact me by sending text messages or emails, using the email address I provided. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable. I/We have read this disclosure and agree that Rockdale Family Practice, PC, its employee and/or agents may contact me/us as described above.

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

Print Name **Email Address**

○ **I would like to receive (MAILED) PAPER statements** ○ **I would like to receive (EMAILED) ELECTRONIC statements**

Billing Address **City** **State** **Zip Code** **Phone Number** ( )

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE **DATE**