

EXPRESS CARE OF THE SHOALS

FINANCIAL POLICY

Patient Name:	Date of Birth:
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Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care at the lowest possible cost. Please understand that the payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

In order to achieve the practice goals of providing the finest medical care at the lowest possible cost, we need your assistance, and your understanding of our payment policy.

FULL PAYMENT FOR PROFESSIONAL SERVICES IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, MONEY ORDERS, DEBIT AND CREDIT CARDS.

All patients who have accounts with outstanding balances will have statements mailed on a monthly basis to their permanent address. After 90 days, if no payments have been received, necessary collection proceedings will begin.

Payments in full for services rendered to a minor are expected at time of service. Parents, guardians, or the accompanying adult will be responsible for this payment.

Returned checks will be assessed additional collection fees. If the checks are not picked up from our business office in an appropriate timeframe, you may be referred to the District Attorney for collection.

Although we are anxious to help you in receiving your maximum allowable insurance benefits, it is your responsibility to understand what your insurance benefits are. You must present your insurance cards to the receptionist prior to seeing the doctor. Any change in insurance or personal information not brought to our attention could result in claim denial by your insurance carrier. By law your insurance carrier should remit payment or deny your insurance claim within 30 days of initial notice of claim. If an insurance problem occurs, you will be asked to assist us in contacting your insurance carrier. We feel it is necessary to work together to resolve any insurance problem. Please remember that few insurance companies attempt to cover all medical costs.

ALL CO-PAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communications. Thank you for understanding our Financial Policy. If you have any questions about this policy, please feel free to talk with a member of our Business Office. We will make every effort available to clarify any misunderstanding you have concerning your balance. We are here to help you.

I have read, understand, and agree to this Financial Policy.

Signature of Responsible Party

Relationship to Patient

Date

