**Financial Policy and Procedures**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Basic Policy:** Pay for service is due in full at the time that service is provided in our office. The office accepts cash, personal checks, debit and credit cards.

**Non-covered Services:** Any care not covered by your existing insurance coverage will require payment in full at the time services are rendered or upon notice of insurance claim denial.

**For Patients with Insurance:** We will bill most insurance carriers (primary and/or secondary) for you if proper paperwork is provided to us. Co-payments, co-insurances and deductibles are due at the time of service.

**Insurance Deductible:** I have paid my insurance deductible for the current calendar year.

Yes \_\_\_\_\_ No\_\_\_\_\_ Unknown \_\_\_\_\_

**Medicare Patients:** We will bill Medicare for you. We will also bill secondary insurance carriers for you.

**For patients without insurance, or if insurance will not cover your services at EPMCC, payment arrangements must be made prior to services.**

**Laboratory Fees:** You may be referred to an outside laboratory for tests. These fees will be billed to your insurance or you by the laboratory. It is your responsibility to use the laboratory contracted by your insurance.

**Signature on File:** For the convenience of our patients and to expedite billing of services on your behalf, EPMCC will maintain your signature on file.

**Assignment of Insurance Benefits and Authorization for Payment:** I authorize payment of medical benefits as determined by my insurance carrier directly to EPMCC. As the responsible party, I agree to pay all charges incurred including those for services not covered by my insurance policy.

**Authorization for Release of Medical Records:** I authorize the release of medical records and information necessary to process the insurance claims for medical benefits.

**Missed Appointments:** Your appointment time is reserved especially for you. Out of respect for all patients waiting for appointments, EPMCC has a 24-hour, one business day cancellation/no show policy. After three (3) cancellation/no show appointments, patients will only be seen on a walk-in basis. Walk-ins will be taken daily, during the following business hours: 9:00 a.m. – 10:00 a.m. and 1:30 p.m. – 2:30 p.m.. Patients will be seen in the following order: Urgent/emergent, scheduled appointments and walk-in. Please note that an appointment for Monday at 10:00 a.m. for example will need to be cancelled be fore 10:00 a.m. the preceding Friday. This same principle applies to holidays.

**Collections:** Account balances not paid within 30 days are considered overdue. Delinquent accounts may be turned over to a collection agency. I understand that I will be charged for and herby agree to pay, all costs and expenses incurred in collecting any past due fees and interest by law. Your signature below signifies your understanding and willingness to comply with this policy.

**Patient Portal:** EPMCC offers patients easy and private access to their health information online. The patient portal is a secure online website that gives patients 24-hour access to personal health information from anywhere with an internet connection, using a secure username and password. EPMCC will automatically enroll you with the patient portal when a valid e-mail address is provided.

I/we do herby consent to and authorize the performance of all treatments, immunizations, minor surgeries and medical services deemed advisable by the providers and staff of Eastern Plains Medical Clinic to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage, excluding only authorized services provided under a valid prepaid HMO contract. I furthermore agree to pay legal interest, collection expenses and attorneys’ fees incurred to collect any amount I may owe. I also hereby authorize Eastern Plains Medical Clinic to release information requested by my insurance company and/or its representatives. I fully understand this agreement and consent will continue until cancelled by me in writing.

**I have read, understand and agree to the above Financial Policy and Procedures.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient