PACIFIC FAMILY MEDICINE CLINIC

Pacific Family Medicine Financial Policy

Overview of Financial Responsibilities

Pacific Family Medicine Clinic Responsibilities: To submit claims to insurance, and statements to the patient/responsible party based on the information made available to us. To provide patients with the network and billing information that is available to us.

Patient/Parent/Guardian Responsibilities: To understand your own insurance network and benefits. To assure that our office is provided with the most current information known about their insurance, and to inform us of any changes in insurance or demographics (address, phone numbers, etc). To within 30 days any balance signed and patient responsibilities (e.g., co-pay, deductible, and co-insurance).

PATIENT INFORMATION

Patient Name (First, Middle, Last)	Date of Birth

Insurance Subscriber Name (If not Patient)	Relationship to Patient	Insurance Subscriber DOB	Insurance Subscriber SS#

Detailed Policies

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Patient must understand their OWN network, plan benefits, and plan limitations. Your health insurance is an agreement between you and your insurance. All charges are ultimately your responsibility, whether you have insurance or not. Not all services are covered under all plans, regardless of whether our doctors consider the care medically necessary. Because there are so many plans, it is not possible for us to know the specific details of your coverage. By making a copy of your card, it does not confirm that we are part of your Network. We always do our best, but failure of our office staff to identify out-of-network plans does not waive your responsibility for payment of services rendered.

We are in network with most traditional [redacted] plans: Our current and best understanding of our network participation is on our website. Our recommendation is to call your insurance about a week before your appointment and ask if your plan's network includes our office, and what patient cost sharing may be applied. You authorize your insurance to pay us directly.

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Bring patient's Insurance Card to every visit. Patients with insurance are responsible for ensuring that our insurance records and other information are up to date. Patients who have not presented a valid active insurance card will be considered self-pay/cash-pay- and they must pay a minimum of $ 50 visit fee at arrival. Patients will have full responsibility for charges if we cannot process a claim due to incomplete, inaccurate or obsolete information. If your insurance changes, you must notify us immediately (even if you do not yet have your card); delays caused by patients can result in the claim being uncollectible from insurance, resulting in patient having full responsibility for all charges.

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Co-Pay, Self-Pay, and Cosmetic services are due at the time of Service. Co-Pay or Self-Pay is always expected at date of service. Patients who fail to pay their co-pay on date of service **WILL NOT BE SEEN**. For patients with high deductible plans, a $50- $100 payment will be collected on date of service towards the office visit. In some cases, we will ask for additional payment towards coinsurance or deductible prior to treatment.

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All procedures and lab services have fees, in addition to the visit fee. Co-pay is usually for office visit only, and does not typically cover procedures (e.g., any type of freeze, removal, incision, injection or other treatment). Estimates for medical procedures are not typically given by the doctor; estimates can be provided, but procedures will typically need to be rescheduled for another day. A skin or tissue sample must be treated as if it could be cancerous, even if it is removed primarily at the patient's request, and will result in both excision/biopsy fees and pathology fees. Labs, imaging, special stains, and other test sometimes must be ordered, and may be furnished by independent sources to complete a diagnosis. We are not responsible for those charges; Contact those billing facilities for billing questions.

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Bills are DUE UPON RECEIPT. We are required to collect CO-PAY, DEDUCTIBLE, AND CO-INSURANCE. Past due balances will be assessed a $ 10 statement fee for each additional statement we must send. Any self-pay, out of network, or other courtesy adjustments will be rescinded if account becomes over 30 days past due. We may charge 18% interest or as allowed by law for any delinquent payment. We exhaust efforts to resolve balances prior to use of a collection agency, however, additional fees up to 50% of your charges may accrue from collections activity.

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Appointment Cancellation Fees. We make numerous efforts to remind you of appointments. Out of courtesy to other patients that need appointments, please notify us if you need to cancel at least one full business day prior. To encourage early notice, the following fees will apply for late cancellation or no shows. $50 for a regular appointment and $100 for a medical procedure, surgery or cosmetic appointment.

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Your health information is protected. We must release patient health information to complete medical operations (e.g., to pharmacies, labs, insurance, other physicians, etc.) Any other release requires your written consent. Our Notice of Privacy Practices is available to you. We may leave a detailed message on your home or cell phone with Health Information.

PLEASE LIST ANY OTHER INDIVIDUALS WITH WHOM WE CAN ALSO DISCUSS THE PATIENT'S CARE IN DETAIL (e.g., spouse, parent, child, etc.)

Name of Health Contact	Relationship to Patient	Primary Phone
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Initial Here

Paperwork Fees. Your provider may ask you to make an appointment or pay an **EXTRA FEE** to have certain forms or letters filled out. Work/School excuses **WILL NOT BE PROVIDED** unless you are seen in the clinic at the time of the illness.

Agreement by Patient (or Parent or Guardian). I have read each policy. I understand them and I agree.

Signature of Patient (or Parent or Guardian) _____ Date _____

Printed Name of Patient (or Parent or Guardian) _____ Date of Birth _____ Social Security Number _____

Street Address (Street, City, State, Zip) _____

Preferred Phone Number ___Cell ____Home _____Work _____Other _____ Email _____

Thank you for taking the time to understand our Billing Policies. Please contact our office with any questions. 650-689-5438