

## **FINANCIAL POLICY**

### **PATIENTS WITH INSURANCE:**

Although we bill your insurance company/medical group for services rendered, you are financially responsible for all services rendered. If payment has not been received within sixty (60) days of billing your health plan/medical group, we may contact you for assistance. Should your health plan/medical group deny coverage for any reason, you will be responsible for that payment in full within thirty (30) days of receipt of your billing statement. For your convenience, we accept cash, Mastercard, Visa, debit cards, and personal checks.

### **DUAL COVERAGE:**

Washington Township Medical Foundation abides by the California State Insurance Laws, which govern coordination of benefits. Therefore, you are responsible for providing us with all billing information for primary, secondary, and tertiary health plans. Dual coverage does not necessarily ensure that you will not have a co-pay for your office visit. If a co-pay is not collected at the time of your visit and subsequently your insurance plan states that a co-pay is due, you will be responsible for paying that co-pay amount thirty (30) days from the date you receive your billing statement. For your convenience, we accept cash, Mastercard, Visa, debit cards, and personal checks.

### **PATIENTS WITHOUT INSURANCE:**

Our fees cannot always be determined in advance, since they depend on actual services provided. If you would like an estimated total amount before being seen, please ask the front desk personnel. Please note that this is only an estimated amount and the actual charge totals may vary from this estimate. Payment for all services is due at the time of service. For your convenience, we accept cash, Mastercard, Visa, debit cards, and personal checks. As a courtesy, a 55% discount will be applied to office and preventative services, and a 25% discount will be applied to in-office surgical procedures at the time of service.

### **CO-PAY POLICY:**

It is your obligation to be familiar with your insurance co-payment and/or deductible amounts. Your co-pay amount must be paid at the time of your visit.

### **NO-SHOW POLICY:**

Washington Township Medical Foundation requires twenty-four (24) hour notice of cancellation for scheduled appointments. In the event that we are not notified twenty-four (24) hours prior to your appointment, you will be charged a \$25.00 "No-Show" fee.

### **DELINQUENT ACCOUNTS:**

Patient accounts not paid within sixty (60) days of the date of service may be turned over to a collection agency.

### **RETURNED CHECKS:**

There will be a \$25.00 service fee for returned checks.

**REFUND POLICY:**

If you have been notified by your insurance company that you are due a refund, please contact our office.

**FEE FOR COPYING MEDICAL RECORDS:**

There is a copying fee of \$15.00 for medical records provided to a patient, insurance company, attorney, etc... However, there is no charge to transfer records to another medical provider upon request.

**OTHER FEES:**

There is a nominal charge of \$25.00 for each form/report (i.e. DMV forms, school/sport physicals, etc...) that requires completion by the physician. However, this fee is waived if there is a *separate* scheduled appointment for this request.

There is a \$10.00 replacement fee for new copies of any immunization record.

There is a \$25.00 fee for any request for letters written (i.e. Health verification letters to insurances/employers, special circumstance letters, etc...) on your behalf as a patient.

**AUTHORIZATION AND ASSIGNMENT OF BENEFITS:**

I authorize the release of any medical information, which may have a bearing on the determination, and/or payment of my claim. I request that payment is made directly to Washington Township Medical Foundation and I acknowledge that I am responsible for payment if this assignment is not honored. I understand that I am responsible for all co-payment, co-insurance, and deductible that I may have with my insurance. I further understand that I have been provided a service and it is my responsibility to know my own insurance coverage and be aware of services that may or may not be covered.

I have read and understand the above policies, and I agree to comply with them. I attest that all information is true and accurate to the best of my knowledge.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_  
(For Minor)