Family Medical Center

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OF HART COUNTY

Financial Policy

Insurance: Insurance is a contract between you and your insurance company. You are responsible for knowing the coverage of your plan. Your insurance determines your benefits. You agree to pay any portion of the charges not covered by insurance.

Payment Options:

1. If you have health insurance, we will bill your primary and secondary for your visits. You agree to pay any portion of the charges not covered by insurance. All co-payments are due at time of service.
2. If you don't have health insurance, you are responsible for paying your bill in full. Patients that pay their bill in full at the time of service will receive a percentage discount.

Financial Assistance:

1. Low income patients may be eligible to receive a percentage discount based on income level.
2. Financial assistance may only be authorized by our account specialist.

Monthly Statement: If you have an unpaid balance on your account, we will send you a monthly statement, however, absence of a statement does not relieve of your responsibility for payment.

No Show/Cancellation Fee: You may be charged a fee if you no show or cancel your appointment without giving a 24 hour notice.

Returned Checks: There is a $50.00 fee for any checks returned by the bank.

Newborn Care: As a courtesy, we will see newborns that have insurance coverage pending for the first 30 days without requiring payment. Infants over 30 days old without active insurance will be required to pay at time of service.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. Family Medical Center reserves the right to verify employment of any patient. The undersigned agrees that if this account is not paid when due, and Family Medical Center should retain an attorney or collection agency for collection, to reimburse Family Medical Center the collection fees of any collection agency, which shall be based on a percentage at a maximum rate of 33 1/3 percent of the amount due at the time your account is placed with a collection agency, and all costs and expenses incurred for any collection efforts on your account, including reasonable interest and reasonable attorney's fees incurred by the collection agency. This contract shall cover all medical treatment and services until revoked by either party in writing**.** In case of suit, you agree the venue shall be in Hart County, Kentucky. We shall have the right to refuse future service to any accounts that are referred to a lawyer or a collection agency.

Workers Compensation: We require authorization by your employer or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for full payment. At your request, we will submit the claim to your medical insurance with a copy of the workers' compensation insurance denial if furnished.

Personal Injury/MVA/Car Accident: It is your responsibility to file a report with the liability or automobile insurance. We will bill your personal injury protection (PIP) insurance or other liability insurance if the information is furnished in a timely manner. If not paid within 30 days from filing, the bill responsibility will be transferred to you. If an attorney is involved in your case, we need their contact information. We do not accept a signed attorney lien as a method of payment nor are we in a position to defer payment obligations while a case settles. If your PIP benefit is exhausted, we will bill your private insurance at your request provided we are furnished the necessary information in a timely manner. Ultimately, you are responsible for payment of the services.

Divorce: In case of divorce/separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. The parent bringing the child in will be asked for payment regardless of the guarantor. If the divorce decree requires the other parent to pay any of the treatment costs, the authorizing parent is responsible for collecting from the other parent.

By signing this agreement, you are responsible for payment of all services that are received.

Patient Name: _____ Guarantor Name: _____

Signature: _____ Date: _____