**FAMILY CARE**

**ASSOCIATES, PC**

*1855 Halcyon Blvd.*
*Montgomery, AL 36117*
*334-530-6387*

# FINANCIAL POLICY

*Our goal is to provide you excellent medical care in a comfortable, personal and cost effective manner. Our financial policies have been developed to help keep the cost of "doing medicine" down, which means lower fees for you. You can help by paying for your care in a timely manner.*

Patient Name: _____ DOB: _____/_____/_____ Account No: _____

## ASSUMPTION OF RESPONSIBILITY

Payments to Family Care Associates, PC may be made by cash, check, VISA or MasterCard. Patients are expected to pay all co-pays, deductibles and/or coinsurance at the time of service. We do our best to include all charges at the time of service but occasionally; charges may be added or modified after the visit. (For example: an additional blood or urine test may be ordered or the level of service may be modified per AMA guidelines).

Family Care Associates, PC reserves the right to charge a fee for delinquent accounts. If ongoing medical care is needed, you are expected to pay on your old balance as well as payment in full for new charges at the time of service. Accounts with balances over ninety (90) days may be turned over to a collection agency unless you are making monthly payments on an approved payment plan.

**Please check each box.**

☐ By signature below, I/we, whether signing as guarantor or as patient, understand and hereby agree that in consideration of services to be rendered to the patient named above, assume the obligation, the financial responsibility and agree to pay upon demand to Family Care Associates, PC all fees for such services and incidentals incurred by named patient. Should the account be referred to an attorney for collection or to a collection agency, the undersigned shall pay reasonable attorney fees, collection fees and other expenses as a court may determine proper.

☐ By signature below, I/we understand that in connection with collection procedures Family Care Associates, PC has the right to request, receive and review all credit information as provided by a licensed and duly operated credit bureau.

☐ By signature below, the undersigned understands that all bills are payable upon presentation and that the guarantor and **NOT** the insurance is responsible for the payment of all services. If the undersigned disagrees with any charges, they will contact this office in writing within thirty (30) days of the billing date.

## ASSIGNMENT OF INSURANCE BENEFITS

☐ I/we understand that insurance billing is a courtesy to our patients. Once my annual deductible has been meet, FCA will bill my insurance company.

☐ I/we understand that I am expected to pay for any co-payment and any non-covered services at the time of my visit.

☐ I/we understand it is my responsibility to pay any balance older than sixty (60) days (even if my insurance company has not paid) and to follow up with my insurance company for reimbursement.

A refund will be issued if FCA receives a payment from your insurance company after your balance is paid. If we have made an error we will gladly submit a corrected claim.

☐ By signature below, I/we hereby guarantee payment of all charges as outlined above and incurred for the account of the above named patient from the date of first treatment until final date of discharge or termination of treatment.

☐ By signature below, I/we hereby assign direct payment of any hospital insurance benefits, medical insurance benefits (including major medical benefits, insurance sick benefits or injury benefits) payable of the liability of a third party or organization, and so forth, payable to or for the above named patient be paid in full.

## NO SHOW AND CANCLELLED APPOINTMENTS

Family Care Associates, PC reserves the right to charge a fee for "no show" appointments with less than a 24 hours notice. Our policy requires: (1) receiving a 24 hour notice if the patient is unable to keep an appointment; (2) applying a fee for missed appointments; and (3) discharging a patient when three appointments are missed without prior notice.

No Show Appointments: 1st = Warning, 2nd = $45.00 to $75.00 charge, 3rd = Discharge from practice.

## AUTHORIZATION TO RELEASE INFORMATION

The undersigned hereby authorizes said Family Care Associates, PC to release sociological and medical information officially acquired in the course of examination and treatment for the purpose of filing for insurance benefits and other financial coverage.

This authorization to release information shall remain in place until all claims have been paid.

**NOTICE: DO NOT SIGN THIS AGREEMENT BEFORE YOU READ, UNDERSTAND AND AGREE TO THE CONDITIONS AS SET OUT ABOVE. YOU SHOULD KEEP A COPY OF THIS AGREEMENT IN YOUR RECORDS.**

**BY SIGNATURE BELOW I ACKNOWLEDGE THAT I HAVE READ, I UNDERSTAND AND I APPROVE ALL OF THE ABOVE.**

Signature: _____ Date: _____

Signature of Patient/Guarantor