



Patient Financial Policy

Thank you for choosing the physicians of ***Post Falls Family Medicine*** as your health care providers. We are committed to providing you with quality care. Your clear understanding of our Patient Financial Policy is important to our professional relationship. If you have any questions about our fees, our policies or your financial responsibilities, please do not hesitate to contact our billing department at 208-773-4097. Please take time to carefully review the following information and return this form to the front desk with your signature and today's date.

We require that all patients complete our Patient Financial Policy prior to seeing the physician. It is your responsibility to notify our office of any patient information changes (i.e., address, name, insurance information, etc.).

INSURANCE

- It is the patient's responsibility to provide our office with current insurance information. We will ask for your insurance card at your first visit and will make a copy for our records.
- If current information is not obtained at the time of service, it will become the patient's responsibility to pay the entire balance until current information is provided to our office.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, and pursuant to contractual obligations, we file all your claims for you. However, we will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, co-payments, non-covered charges and "usual and customary" charges. We will supply information as necessary.

You are ultimately responsible for the timely payment of your account.

CO-PAYS

Co-payments are due at the time you check in at the front desk **PRIOR** to your being seen by our physicians.

DEDUCTIBLES, CO-INSURANCE and ESTIMATES:

- Balances related to unmet deductibles and estimation of co-insurance, as per the contract you have with your insurance, is to be paid at the time of service.
- For surgical and in-office procedures, an estimation of patient responsibility will be provided to you and is to be paid **in full** PRIOR to services being rendered.
- Additional balances due, if applicable, will be billed to you after the insurance carrier has processed the claim.

UN-PAID/OUTSTANDING BALANCES

- We ask that full payment to be made at the time of service unless prior arrangements have been made through the billing office.
- If your insurance company has not paid the balance in full, you will receive a statement notifying you of the amount due.
- You may call our billing office at 208-773-4097 to set up payment arrangements if necessary. Any overdue balances may be considered for further collection activity.

Forms of payment accepted: Cash, Checks, Visa, MasterCard, American Express and Discover.



Post Falls Family Medicine Financial Policy (Continues)

RETURNED CHECKS

The charge for a returned check is \$25.00 plus any additional bank charges accrued payable by cash, check, money order or credit card charge.

This will be applied to your account in addition to the insufficient funds amount.

MISSED APPOINTMENTS

Please help us serve you better by keeping scheduled appointments. In the event you are unable to keep your appointment we request, at minimum, a **24-hour notice**.

Failure to provide notice after the 2nd missed appointment will result in a **\$35.00** missed appointment charge.

This charge is the responsibility of the patient and is not covered by any insurance carrier.

CREDIT BALANCES

From time to time, you may accrue a credit balance on your account. If your account reflects a credit balance of **\$20.00 or less**, Post Falls Family Medicine's policy is to carry the balance on the account until your next appointment.

If your account reflects a credit balance of **more than \$20.00**, Post Falls Family Medicine will maintain your credit until our Accounts Receivable staff processes your credit or a request is made by you, the patient, to receive a refund. All refunds are reviewed and processed every **45 days**, if you make a request please allow ample time for review of your entire account and processing through our billing department. You can contact our billing department at 208-773-4097 regarding any credits on your account.

Like all businesses it is our intention to thoroughly explain our financial policies and set forth our expectations. Your assistance and cooperation is appreciated.

We are pleased to have the opportunity to meet your health care needs and encourage you to contact our billing department (208) 773-4097 with any questions or concerns.

I have read Post Falls Family Medicine Patient Financial Policy and acknowledge my responsibilities by affixing my signature below.

Patient Name (please print)

Patient Date of Birth

Patient/Responsible Party Signature

Date

