DESERT WELLS
Family Medicine

PAYMENT POLICY

Thank you for choosing us as your primary care provider. We are committed to providing you with quality health care. Please read this payment policy, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

INSURANCE Desert Wells Family Medicine contracts with many insurance companies. It is the patient's responsibility to verify with their plan that Desert Wells Family Medicine is a participating provider. It is also the patient's responsibility to find out what coverage options and benefits are with your insurance plan. Desert Wells Family Medicine will submit insurance claim forms along with the medical records necessary to obtain payment from your insurance company. The patient is responsible for all charges regardless of insurance coverage. If you are not insured by a plan we are contracted with, payment in full is due at each visit. If you are insured by a plan we are contracted with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Please contact your insurance company with any questions you may have regarding your coverage.

CO-PAYMENTS AND DEDUCTIBLES All co-payments must be paid at the time of service. Deductibles must be paid upon receipt of the invoice. A $40 fee will be charged in the event of a returned check.

NON-COVERED SERVICES Please be aware that any services considered to be a non-covered benefit by your insurance will be your financial responsibility.

PROOF OF INSURANCE We must obtain a copy of your current insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

CLAIMS SUBMISSION We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request.

NONPAYMENT Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and you and your immediate family members may be discharged from the practice.

MISSED AND LATE APPOINTMENT POLICY Our office has a 24 business hour cancellation policy, otherwise there will be a $30 fee billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

I have read and understand the payment policy and agree to abide by its guidelines.

_____ _____
Patient's Name (Print) Patient's Signature

_____ _____
Date of Birth Today's Date

CONSENT FOR PHONE CONTACT

Desert Wells Family Medicine MAY leave a voice mail message for me on my:

☐Yes Home Phone: _____
☐Yes Cell Phone: _____
☐Yes Work Phone: _____
☐Yes Other (specify): _____
☐**Never leave any medical information on any voice mail message for me, simply ask me to call back. Please note, this does not apply to messages regarding unpaid bills.**

Desert Wells Family Medicine MAY discuss medical information regarding me with:

☐ Yes My husband/wife/partner (*Name/Relationship*):
_____
☐ Yes Power of Attorney (*Name/Relationship*):
_____
☐ Yes Other (*Name/Relationship*):
_____

_____ _____
Patient's Signature (Parent or Legal Guardian If a Minor) Date

1/03/2014