Cogent
Family Healthcare

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FINANCIAL RESPONSIBILITY POLICY AGREEMENT

Thank you for choosing **Cogent Family Healthcare** as your primary healthcare provider. We are committed to providing you with quality, personal health care and appreciate your commitment to adhere to this **Cogent Family Healthcare Financial Responsibility Policy Agreement**. By understanding our policy, we can provide you with the best service. Agreement with this policy is required for all medical care.

Insurance: We participate in most insurance plans, including Medicare. With respect to your insurance coverage, it is important to note the following:

1. If you are not insured by a plan we do business with, payment in full is required at the time of service.

2. Many patients opt to participate in a high deductible insurance plan. This means that even while paying monthly premiums, healthcare costs will be an out of pocket expense until the deductible amount is met each year.

3. All co-pays and unsatisfied-balances must be paid at the time of service.

4. Some insurance plans cover a basic annual preventive exam at no charge to the patient. If you decide to avail of only the preventive services that are covered at no charge to you, then you must contact your insurance company to obtain a written list of those covered services, and bring it to your preventive exam, so that we can select services from the list provided.

   Initials: _____

5. Before seeing a Physician, we must obtain a copy current valid insurance card as proof of insurance. Please notify us of any changes in insurance coverage prior to time of service.

6. If you are insured by a plan we do business with, but can't provide an up-to-date insurance card, a payment deposit for each visit is required until you can verify your coverage with us. Deposits will be applied towards charges incurred, but may not represent payment in full for services. The payment will not be processed for **FIVE (5)** business days, allowing you time to provide our office with up-to-date insurance card information.

7. We are unable to ensure that we are part of your plan. It is your responsibility to determine whether we are included in your provider network. If we not, in fact, part of your plan,

payment in full is expected within 30 days of receipt of an invoice from us. Knowing your insurance benefits – including eligibility, deductibles, co-pays, out-of-network benefits, and covered benefits is ***your*** responsibility. Please contact customer services at your insurance company for questions regarding your coverage.

Initials: _____

8. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. As such, please be aware that the balance of your claim is your responsibility, if your insurance company does not pay your claim. As a courtesy, we will submit your claims and assist you in any way reasonable to help you get them paid for up to 60 days after your office visit. If we are unable to resolve problems with your claim within 60 days due to issues outside of our control, then you must pay your visit balance within 30 days of receipt of an invoice and work with your insurance company directly to satisfy your benefit. If, your insurance company later pays all, or a portion, of the balance that you paid to us, our office will refund you that amount with 30 days of receipt of payment.

   Initials: _____

9. If your account is over **60 days** due past the date of billing, **you will be charged a $25 additional processing fee** to cover increased administrative costs associated with handling your payment. Please be aware that if a balance remains unpaid after **90 days past due**, we will refer your account to a **collection agency** and you and those for whom you are guarantor **may be discharged from this practice**. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, services will be provided on a cash-pay, prepaid basis.

   Initials: _____

10. If your healthcare plan requires approval or authorization for referrals to a specialist, radiological imaging, medical facility care etc. it is your responsibility to inform our office of this requirement prior to referral.

11. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. Should you choose to receive the service, you must pay for these services in full at the time of visit, or within 30 days of receipt of an invoice from us, indicating that the services are not covered.

12. We do not bill travel insurance carriers. However, you will be provided with all of the information necessary to submit a claim to your insurance company.

13. In cases of auto accidents, we cannot bill your insurance company. However, you will be provided with all of the information necessary to submit a claim to them.

Administrative Services Charges and Patient Responsibilities: Our practice is committed to providing the highest quality of service to our patients, while keeping the charges for administrative services as low as possible. All such administrative fees must be paid at the time of service.

1. **Returned Checks.** If your check is returned you will be charged the Bank Fee relating to the returned check plus a $25 processing fee. The invoice and all relevant fees must be paid in full within 30 days of being notified of the issue.

2. **Letters/Form Completion.** At the discretion of the Physician, letters and forms requiring medical review or lengthy time to completion are subject to an administrative fee. The fee for letters is $50 to $100, depending on complexity, while the fee for forms ranges from $25 to $50.

3. **Request for Medical Records.** Administrative fees for medical record compilation range from $35 to $50, depending on the length of the record.

4. **Other Complex Administrative Services**. At the discretion of the Physician, other complex administrative services range in fee $25 to $75, depending on complexity.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. This policy applies to your account as of the time of your next visit. Please let us know if you have any questions or concerns.

I have read, understand, and agree to comply with the terms outlined in the Cogent Family Healthcare Financial Policy Agreement.

_____ _____

Signature **Date**

_____

Printed Name