JORDAN MEADOWS AND HUNTER MEDICAL CENTERS

Financial Policy

Thank you for choosing us as your health care provider. We are committed to making your treatment a success. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment.All patients must also complete our Patient Information Form before seeing a healthcare provider. PATIENT PORTION IS DUE AT TIME OF SERVICE.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.We cannot bill your insurance company unless you give us your correct information.The balance is your responsibility whether your insurance company pays or not. If you do not have your co-payment/deductible, you may be asked to reschedule your appointment.

Please be aware that some, and perhaps all, of the services provided may be "non-covered services" and may not be considered "reasonable and necessary" under the Medicare Program and/or other medical insurance programs. Services may be considered "pre-existing" and not payable under your contract with the insurance company. All charges are ultimately your responsibility.

Minor Patients

The adult accompanying a minor and/or the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/Master Card, etc., or payment by cash or check at time of service has been verified.

Missed Appointments: Unless cancelled at least 24 hours in advance, missed appointments will be charged $30. Please be sure to call us if you cannot make it to your appointment.

Right to treatment

I understand that by signing this form I authorize you to use and disclose my health information, to carry out treatment (including direct or indirect treatment by other healthcare providers involved in my treatment), and to obtain payment from third party payers (i.e. my insurance), as well as the day-to-day healthcare operations.

Collection Action

I certify the information I have given on this form is true and correct. I understand that, regardless of my insurance status, I AM ultimately RESPONSIBLE for the balance of my account for all professional services rendered by Jordan Meadows and Hunter Family Medical Centers and that if I have insurance coverage, my insurance will be billed by this office. However, it is my responsibility to make sure the insurance pays. I further understand that should collection action become necessary, the responsible party agrees to pay an **ADDITIONAL 35% COLLECTIONS FEE** and all legal fees, including attorney's fees and court costs. Returned checks are collected by Express Recovery for Jordan Meadows and Hunter Family Medical Centers. We cannot accept payment for returned checks. Returned checks go directly to the collection agency.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

_____

PLEASE PRINT PATIENT NAME