Family Care of Fairview, PA

Office and Financial Policies

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policies allows for a good flow of communication and enables us to achieve our goal. *Please read each section carefully and initial*. If you have any questions, do not hesitate to ask a member of our staff.

Appointments

1) We value the time we have set aside for each and every patient. We do not double book appointments. If you are not able to keep an appointment, we would appreciate 24-hour notice. **There is a charge of $25 for missed appointments. ($50 for missed ultrasound appointments)** This charge is not filed to insurance and will be *patient* responsibility.
2) If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, in certain situations it may be necessary to reschedule your appointment.
3) We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
4) Before making an annual physical appointment, check with your insurance company as to whether the visit will be covered as a wellness visit.

Initial: _____

Insurance Plans

Please understand our office files insurance as a courtesy to our patients.

1) It is your responsibility to keep us updated with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment of the visit.** We MUST have a current copy of your insurance card on file in order to file a claim. Please be prepared to present your card at each visit if necessary. **If you do not have a card or if your policy is not current/active, you will be responsible for payment of the visit.**
2) Some insurance companies require you to specify a primary care physician. If we are your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not yet been informed that we are your primary care physician, you may be financially responsible for your current visit.
3) It is your responsibility to understand your benefit plan with regard to, for instance, covered services and participating laboratories. For example:
    a. Not all plans cover annual healthy (well) physicals, sports physicals, vision screenings and other services. If these are not covered, you will be responsible for payment.
4) It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered.

Initial: _____

Financial Responsibility

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
2) **Co-payments, coinsurance percentages and deductible estimates** are due at the time of service. For patients with deductibles to meet, we collect $50 up front because it is almost impossible to know the allowable amounts for each insurance and policy- charges are then filed and an additional bill may be sent based on the insurance assessment of the claim)

3) Self-pay patients are expected to pay for services in FULL at the time of the visit. A 25% discount is applied for self-pay patients.
4) If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit.
5) Patient balances are not to exceed $100 before additional attempts at collection may be made. We cannot extend credit or allow large balances to build. If a balance exceeds $100, payment will need to be made towards that balance prior to future appointments.
6) We accept cash, checks, Visa, and MasterCard, American Express, Discover credit and debit.
7) A $35.00 fee will be charged for any checks returned for insufficient funds.

Initial: _____

Forms

1) There is a $15 per page fee for any forms that are filled out by our providers/staff outside of an office visit. Forms exceeding 5 pages will be charged based on time taken to complete the form.

Initial: _____

Medical Records

1) For your protection all medical records REQUIRE a signed consent before they can be released to or received from another party.
2) Our office utilizes a third party service called Healthport to process all medical record requests sent from our office. Be aware that a charge may apply depending on circumstances. Please allow 7-10 days for these requests to be processed (*note there may be rare instances that this could take up to 14 days)

Initial: _____

Prescription Refills

1) For medication refills, we require 48 hours' notice, during regular business hours. Please plan accordingly. Due to the high volume of medication refills/requests, we ask that you contact your pharmacy to verify if the prescription has been completed.

Initial: _____

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s)_____

Patient Signature_____ Date_____
If patient is a minor:
Parent/Guardian Name:_____ Relationship:_____

Parent/Guradian Signature:_____ Date_____