



Channell Family Medical Group
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Office Policy

Thank you for choosing us as your provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

- 1. Office hours.** Our office is open Monday to Friday, 9:00am to 5:00pm. We are closed for lunch from 12:00pm to 2:00pm. We are closed for all major holidays; please call our offices for exact dates and times.
- 2. Same day appointments.** If you are sick and need to be seen, please call our office as soon as you start to feel sick, and we will try to work you in. Please be aware this is considered a sick visit and we will not do any preventive services at the same visit.
- 3. Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan with which we are contracted, payment in full is expected at each visit. If you are insured by a plan with which we are contracted, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. If you have multiple insurance coverage, we are required by our contract to bill your primary first, secondary second, etc....
- 4. Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. **This arrangement is part of your contract with your insurance company.** Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
- 5. Non-covered services.** 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. You must pay for these services in full at the time of the visit. Please be aware for a TB test the fee is \$35.00, we do not bill any insurances for this charge.
- 6. Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid 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 the claim.
- 7. Claim 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. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
- 8. Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. Please be aware our contract with your insurance company does have timely submission requirements. If you do not notify us within those requirements, you will be responsible for the visit.
- 9. Self-pay patients.** Please be aware before your visit, we require a deposit for all self-pay patients: New Patients-\$200.00 for Patricia Guevara-Channell, M.D. and \$175.00 for Daniel Channell, M.D.. For establish patients-\$100.00 for Patricia Guevara-Channell, M.D. and \$75.00 for Daniel Channell, M.D., that will be collected by the receptionist upon check in. Based on the complexity of the visit, your account will be reconciled, after you see the doctor, any balance due will be collected then. On an average, plan to spend approximately 20-30 minutes with the doctor for a new patient and 10-15 minutes for an established patient.
- 10. Office Visits/Physicals/Procedures.** Office visits are an evaluation and management of a medical condition/illness/injury. Physicals (Well Exams/Well Woman Exams/Well Child Exams) are visits for **prevention** of medical conditions/illness/injury. Our office does not provide service for more than one type of treatment per day.
- 11. Sport/camp/work physicals.** Please be aware, most insurance companies do not cover physicals for those reasons. We will bill your insurance but balance will be responsibility of the patient.

12. **Account Credits.** Our office will not issue a refund for a credit less than \$25.00, unless requested by the patient. We will hold the credit on your account for future services. Accounts will be audited within 30 days of payment, once all visits have been finalized. All refund checks must be picked up in person by the patient and signed for once received.

13. **Finance fee.** After 30 days of a balance due, finance charge of 18% per year will accrue.

14. **Past due accounts.** If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer collection of the balance to a collection agency/lawyer, you agree to pay all fees, which we incur, plus all court costs.

15. **Return check fee.** There will a fee of **\$35.00** for all returned checks. This is a crime and if amount of check and fee is not paid immediately, we will report you to the San Bernardino County District Attorney. We will no longer be able to accept checks for all future payments.

16. **Missed appointments.** Our policy is to charge **\$30.00** for missed appointments for establish patients not canceled within 24 hours before your appointment. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

17. **Form charge.** Our policy is to charge for form completion. The patient will be required to pick up the completed form. Please be aware forms will not be accepted until paid for and it may take up to 7 working days to complete the forms. Our fees per form are:
 - EDD (state disability) \$15.00
 - Physical Exams (sports/school/work) \$15.00
 - FMLA and Long Forms \$20.00, with Medical Records \$30.00
 - DMV \$45.00

18. **Medical records.** We will need your written authorization to send copies of our medical records to yourself and/or another physician. This service will be provided at no charge to send records to another physician; however, should you prefer to obtain your records directly, a processing and preparation fee of \$35.00 must be collected before we can release your records.

19. **Phone call charge.** Current medical guidelines permit for patients to be charged for phone calls and emails from patient to physician. We will bill your insurance but balance will be the responsibility of the patient. Fee based on time.

20. **Phone Messages.** Please allow 24 hours for all non-urgent phone messages. Urgent messages will be answered immediately.

21. **Results.** Please allow **7 working days** before calling our office to inquire about results.

22. **Medication Refills.** Please call your pharmacy for all refill requests. Please allow **5 working days** to process a refill request. All patients with chronic conditions or on Hormone Replacement Therapy will need to see the physician every 3-4 months. And prescriptions will only be given for 4 months at a time.

Please do not bring children to our office, unless they are the patient to be seen. If you must bring children, please make sure there is a responsible adult to watch them at all times. You will be financially responsible for any damages that occur.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. By signing this form, you give Channell Family Medical Group permission to use any information in your chart to contact you for any reason including to collect a debt. Thank you for understanding our office policy. Please let us know if you have any questions or concerns.

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

Signature of patient or responsible party

Date