Financial Policy

Thank you for choosing Generations Family Practice as your healthcare provider. We are committed to providing you the best quality medical care. We look forward to establishing a lasting relationship and partnership with you. As part of this relationship, we wish to establish our expectation of your financial responsibility.

Self-Pay: Patients without insurance coverage will be required to pay for all services at the time they are rendered. We do offer a discounted rate to self-pay patients.

Insurance Collection: Your medical insurance policy is a contract between you and your insurance carrier and differs from individual to individual, even if from the same insurance carrier. Our providers should not be expected to know your individual insurance benefits or coverage amounts or terms, and you should not take any opinion they may offer as fact. As a courtesy, we will bill your medical insurance carrier for services we provide. We will be diligent in making sure your insurance is filed accurately and promptly. It is your responsibility to ensure we have the most current copy of your insurance card, demographic and contact information. If your insurance cannot be verified at the time of service, you will be responsible for payment at time of service. You are responsible for any balance remaining after your insurance carrier has processed your claim (60-90 days). Should your insurance company reimburse us at a later date, we will gladly refund/reimburse you.

Co-payments, Outstanding Balances and Fees: All co-payments, outstanding balances and fees for services not covered by your insurance policy are due at the time services are rendered. For any questions regarding coverage for any services/treatments, we encourage you to contact your insurance carrier to review costs. As a convenience, we accept all major credit cards, debit cards, checks and cash.

Out of Network/Non-Participating Insurance Carriers: If your insurance carrier considers us 'out of network' or does not participate with us, you are responsible for payment in full at the time of service. We will gladly provide any proof visit/receipts, etc.

Consent Orders: This office is not a party to your child support consent order or divorce decree. The financial responsibility for the minor rests with the accompanying adult.

No Show/Cancellation Policy: Missed appointments represent a cost to us, to you and to other patients who could have been accommodated. Appointments missed or not cancelled at least 24 hours before the appointment time will result in a $75.00 fee. **Appointments can only be cancelled by calling during regular business hours**. Please help us serve you better by keeping your scheduled appointment.

Form Charges: Starting May 1, 2014, requests for completion of several types of forms and correspondence will incur fees. Fees are strictly based on the amount of time required to fulfill your requests.

Examples include:

- disability forms
- letters /correspondence requested from patients, insurance companies or third parties

Charges for these services will range from $25 for a basic form, and vary depending on the amount of time required by the provider to complete the request.

In an effort to provide you with financially viable quality of care, we thank you in advance for understanding the necessity of adding these charges.

Past Due Payments: Just as we make every effort to accommodate you when you are in need of medical care, we expect you to make every effort to pay your bill promptly. If you have financial hardship or you are unable to pay your bill in its entirety, please contact our billing manager to discuss payment options. If your account becomes delinquent (past 30 days) your account will be subject to interest and collection costs.

Patient Name ____ DOB: ____________________

Financial Policy Continued

Returned Checks: A $35.00 fee will be charged on all returned checks. Additionally, we will no longer be able to accept checks from you for yourself or any members of your family.

Transfer of Care: When transferring care to another provider, we will request and require you to close out any balances due. Charges for medical records will be calculated according to the North Carolina General Statutes. Payment is due at the time the records request is made.

I authorize Generations Family Practice to release all requested information concerning my medical treatment to my insurance carrier. I further authorize my insurance company to pay from the proceeds of benefits of any recovery or insurance payments in my case, directly to the provider(s) of this office, for their professional services rendered.

Generations Family Practice reserves the right to dismiss any patient from the practice who consistently fails to meet this policy or who refuses to sign this agreement. By signing below, I understand and agree to the terms of this office's Financial Policy.

Signature: ____ Date: ________________