FINANCIAL POLICY

THE MAXWELL GROUP

Thank you for choosing The Maxwell Group as your primary care physician office. **Please carefully read and sign below.** This policy has been put in place to ensure that financial payments due are recovered. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager and billing department will be glad to discuss these policies with you.

1. I understand that all copayments and outstanding balances are due at the time of service. If I do not have my insurance card, and/or copayment, my appointment may be rescheduled based on availability until such time that I can provide the required documents or payments.

2. I understand that although we are contracted with several insurance companies, it is my responsibility to know my insurance benefits.

3. I understand that if I do not have the correct PCP assigned by my insurance company that my appointment will be rescheduled.

4. I understand that if my insurance company has not paid a claim on my behalf within 90 days because of information that I have not provided, the balance will be transferred to my account and I will be responsible for payment. If we receive payment at a later date, we will reimburse you.

5. I understand that a $35 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order or cash).

6. I understand that there is a charge of $35 for any forms that I request the doctor to complete on my behalf. The payment for completion of these forms will be paid when the forms are accepted for the doctor to complete. These forms include but are not limited to FMLA paperwork, Life Insurance forms, Assisted Living forms and any other form requiring doctor completion when the patient is not present. Document completion could require you to be seen by a provider. Please allow 7-10 business days for completion.

7. I understand that there may be fees associated with medical records requests and that I may be responsible for these fees.

8. I **have read and I understand the above Financial Policy and I agree to abide by its terms.**

______________________________	______________________________
Printed Name (patient or guarantor)	Relationship
______________________________	______________________________
Signature (patient or guarantor)	Date