PATIENT FINANCIAL & PAYMENT POLICY

January 2, 2018

Thank you for choosing Apollo Physicians. Our mission is to provide the highest quality care that is convenient and comprehensive to our patients. This financial payment policy is an agreement between Apollo Physicians Medical Group (APMG) and you, the patient or responsible party. By signing the Patient Financial and Payment Policy you are acknowledging that you understand and agree to our financial and payment policies.

Patient Responsibilities: Full payment is due at time of service for all patients who have not met their deductible or do not have insurance. You must provide us with a current insurance card and billing information at each visit. Your insurance policy is a contract between you and the insurance company. It is your responsibility to know your insurance policy and benefits and be familiar with your coverage. If pre-authorization is required by your plan, it is your responsibility to advise APMG. You are responsible for all unpaid balances. APMG will bill your insurance and make every effort to ensure claims are promptly and correctly submitted. _____

Credit & Finance Charge Policy and Agreement: I understand that I am financially responsible for all charges regardless of third party involvement. I agree to pay any deductible, co-insurance, co-pay or any service(s) deemed a "non-covered benefit" by my insurance carrier at the time the service was rendered**. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. If your account is sent to a collection agency you may incur additional interest fess and/or legal fees.** _____

Methods of Payment: We accept payment by cash, check, VISA, Mastercard, American Express, Care credit, and Discover.

Disability and other forms: We realize that special forms are sometimes necessary to provide documentation of medical conditions. Completing forms is time consuming and generally falls outside of the contractual relationship between you and your insurance company. We will be happy to complete your form. A $25 fee will be charged for each form. Please allow 7-10 days for your request. _____

Returned Checks: There is a fee of $35 for any checks returned by the bank. _____

If payment arrangements cannot be agreed upon, the amount due will be considered delinquent and may be subject to legal action or assignment to a collection agency. Additionally, failure to pay delinquent accounts may result in termination of care from APMG. Checks or other instruments returned by a financial institution will be forwarded directly to a collection agency for collections. _____

Past Due Balances: Patients who have a previous collection agency balance and wish to receive service are asked to pay any new charges at the time of service in addition to paying off the old debt, except in the case of a medical emergency. _____

Print Name: _____ Date of Birth: _____

Signature: _____ Date:_____