

# Family Healthcare Partners

## Financial Policy

**Thank you** for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment for services provided is considered part of your treatment. The following is a statement of our financial policy.

**All patients are required** to complete our patient information and insurance forms before being seen by one of the health care providers.

**We Accept Cash, Checks, Visa, MasterCard, Discover and American Express.**

### **Insurance**

Your insurance policy is a contract between **you and your insurance company**. We are unable to bill your insurance company unless you have provided us with your insurance information. If we are a participating provider with your insurance company and their health plan.

**ALL Co-payments are due at the time of service.**

If you are a member of an insurance company and/or health plan that we are not participating providers with, **you are responsible for payment of your first visit at the time of service**. We accept assignment of insurance benefits after your initial visit. **The balance is your responsibility**. If your insurance has not paid your account in full within 45 days, the balance will be your responsibility and **you** will need to follow up with your insurance company.

We will be glad to assist you by providing account information, itemized statements, etc.

### **Usual and Customary Charge**

Our practice is sensitive to the increasing cost of health care. We set our fee schedule in accordance with what is usual and customary for our area. **You** are responsible for payment regardless of any insurance company's determination of usual and customary charges.

### **Self Pay Patients**

Self pay patients are responsible for **FULL payment AT the time of service**.

### **Service to Minors**

The adult who accompanies a minor will be held responsible for full payment.

For unaccompanied minors, **payment by cash or check at the times of service** must be verified.

**The following is required by law: PLEASE Read-Sign and Date**

I hereby authorize Family Healthcare Partners, LLC to release any information to the Health Care Financing Administration, Pennsylvania Medical Assistance, and/or my insurance company for any examination and/or treatment by Family Healthcare Partners, LLC and any physician or practitioner of Family Healthcare Partners, LLC.

I authorize the release of Medicare information relating to the treatment that I have received and also to the carrier names as my Medigap insurer, necessary information needed to determine payable benefits for the services rendered.

I understand that my signature verifies that I have received the necessary procedure, treatment and/or medical items administered by the physician(s) of Family Healthcare Partners, LLC that I have requested.

I understand that payment for services, procedures and/or items may be from Federal and/or State Funds and any false claims, statements, documents or the concealment of material may be prosecuted by laws which are applicable to the State and Federal Government.

I hereby request that payment be made directly to Family Healthcare Partners, LLC for any and all services rendered. By this, I authorize Medicare, Pennsylvania Medical Assistance and/or any other insurance company to forward payment to Family Healthcare Partner, LLC on my behalf.

I understand that all services rendered to me by Family Healthcare Partners, LLC were necessary for the treatment of my medical condition and that **I am financially responsible for any and all** charges which Medicare, Pennsylvania Medical Assistance, and/or an other insurance company will not pay, including, but not limited to co-insurance (co-payments), deductibles and any non-covered procedures or services.

**I agree to pay in full**, all services financially due by me personally, **within 30 days** of receiving the billing statement sent by Family Healthcare Partners, LLC.

I understand and agree that this written authorization will remain in effect until I request, **in writing**, a termination of this authorization to Family Healthcare Partners, LLC.

**I have read the above Financial Policy.**

**I understand and agree to the terms of this policy.**

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Signature of Patient or Responsible Party

Date