Physicians MEDICAL GROUP
825 OAKLEY SEAVER DRIVE | CLERMONT, FL 34711 | TEL: 352-536-1764 | FAX: 352-536-1765

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. As part of our services we request that the patient or responsible party you read the following financial policies prior to services being rendered.

INSURANCE

1. **As a courtesy, we will file your insurance**. It is your responsibility to make sure that we receive prompt payment from them. It is useful to maintain frequent contact with your insurance carrier to make sure they are paying, as they should. It is your responsibility to know your insurance. If insurance does not pay, you are responsible for payment. _____Initial
2. Please be thorough with your insurance information if you expect us to file for you. Bring your insurance card with you and any authorization you may have. You will be responsible for any unpaid balance due to lack of information. _____Initial
3. Your insurance will send you an explanation of benefits that explains what they have paid to our office. This is a record that you must keep on file. If you do not agree with their payment, please contact the insurance company directly. _____Initial
4. **If your insurance denies payment on your account, you will be asked to pay immediately.** Remember, you and/or your employer pay the monthly insurance premiums. Your insurance company is accountable to you, not us. Do not hesitate to contact them if you disagree with their payment or to find out the status of your claims. _____Initial

FEES

1. We will collect your Co-Payment, Coinsurances, deductibles and/or fees for uncovered services prior to seeing the doctor. _____Initial
2. I understand that there is **a $20 charge** on all returned checks and a **$35 charge** for scheduled appointments cancelled without 24 hours prior notice or failure to show up for a scheduled appointment. I further understand that payments for these charges can only be made by cash or credit card. _____Initial
3. Collections Policy - Once your account is turned over to a collections agency, all parties linked to the account will be immediately dismissed from the practice. These accounts will be subject to a collections fee and applicable interest. Please help keep your account out of collections by submitting timely payments for your outstanding balances. _____Initial

TO ALL MEDICARE PATIENTS: We will continue to participate as Medicare providers. We will bill Medicare as well as secondary insurance, but if payment is not received from your secondary insurance in 60 days, you will be notified and must pay our office the balance due. You must then contact your secondary insurance to pay you for the balance you paid our office. We will not file claims to tertiary insurance policies. _____Initial

SELF-PAY PATIENTS: This category includes those people with no insurance and those patients who have an indemnity plan and wish to file their own insurance. Payment for medical services is expected on the day the service is rendered. We accept Cash or Credit Card. If you will not be able to pay for services in full, you must contact our office to make a payment agreement before coming to see the doctor. _____Initial

MINOR PATIENTS (Under the Age of 18): The adult accompanying a minor (parent/guardian) is responsible for full payment at the time of service. For unaccompanied minors, payment arrangements need to be made in ADVANCE and we must have parent/guardian's written permission along with a copy of their photo I.D. prior to treatment of a minor. _____Initial

LABS/IMAGING: If you have lab work, pathology, imaging or additional testing that is sent to an outside lab/facility, that facility will file your insurance for you. If you have questions regarding billing or claims payment, call the facility directly. We do not have information regarding billing for facilities you visit outside of our office. _____Initial

SIGNATURE OF PATIENT OR LEGAL GUARDIAN: _____

PATIENT'S NAME: _____ **DATE:** _____

PRINT NAME OF PATIENT OR LEGAL GUARDIAN: _____