Family Health, PC
19020 Fort Street
Riverview, MI 48193

Patient: _____ Account Number: _____

Payment Policy

Thank you for choosing us as your health care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance**. We participate in most insurance plans, including Medicare. If you are not insured by a plan, we do business with, payment in full is expected at each visit. If you are insured by a plan, we do business with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles**.
   -All co-payments are due and must be collected at the time of check in.
   -Insurance deductibles and fees for services not covered by your insurance policy, if known at the time of the visit are due at the time the service is rendered.
   -We accept cash, check and most credit cards.

3. **Non-covered services**. Please be aware that some of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. It is your responsibility to know what your insurance covers or not.

4. **Proof of insurance**. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims submission**. We will submit your claims to your insurance company. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes**. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **Paperwork without an appointment.** FMLA and disability paperwork dropped off without an appointment is a $20 fee and can take 3-7 business days to complete due to the length and amount of paperwork. So plan accordingly.

8. **Nonpayment**. If your account is over 60 days past due, you will receive a pre-collection letter. Your account must be paid in full before any future appointments can be scheduled. Partial payments will not be accepted unless otherwise negotiated. Please contact the billing department to make monthly payments.

9. **Cancellation, Rescheduling or Missed appointments**. Family Health requires a minimum of 24 business hours' notice for cancelling or rescheduling appointments; this includes last minute cancellations and no shows. Anything less than 24 business hours' notice will incur a $20 fee for general practice appointments to your account and will need to be paid prior to scheduling any further appointments. This fee is your responsibility and cannot be billed to your insurance carrier.

10. **Outstanding Balance Policy.** New appointments cannot be scheduled until outstanding balances are paid in full.

Our practice is committed to providing the best treatment to our patients. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

X _____ X _____

Signature of patient or responsible party **Date**