PRIMARY CARE HEALTH PARTNERS
FINANCIAL POLICY

PAYMENT IS EXPECTED WHEN YOU COME IN FOR AN APPOINTMENT

- Co-payments, where applicable, are due upon check-in.
- Any deductible is due as soon as the amount can be determined.
- You are responsible for understanding what your insurance plan will cover or not cover.

NOTIFY US OF ANY CHANGES IN YOUR ADDRESS AND/OR INSURANCE

- If your insurance changed, bring your new insurance card with you.
- Please contact your insurance company with insurance questions.

STATEMENTS ARE GENERATED FOR OUTSTANDING BALANCES

- If you are responsible for more than one patient account, we may offset an overpayment in one account to another account.
- We will assess a **$25.00 service fee** for any checks returned unpaid.
- If payment is not received within **21 days** of the statement date, your account will be considered delinquent.

WE USE COLLECTION AGENCIES FOR DELINQUENT ACCOUNTS

- If your account is delinquent, we may list your default with credit reporting agencies.
- If you have a balance due, payment may be required before appointments are scheduled.
- We may assess a **$25.00 collection fee** to all delinquent accounts sent to our collection agency.

NOTIFY US TO CANCEL AN APPOINTMENT

- If you need to cancel an appointment, notify us **at least 24 hours before** the appointment.
- If you miss an appointment or are late in cancelling it, we may assess a **$25.00 fee**.
- If you frequently miss or cancel appointments, you may be discharged from our practice.

WE USE AUTOMATED SYSTEMS FOR REMINDERS AND ACCOUNT FOLLOW-UP

- You authorize us or our agents to contact you using any contact information you provide to us including e-mail addresses and wireless telephone numbers (please note some wireless phone plans assess usage fees).

I have read the above Financial Policy of Primary Care Health Partners and agree to its terms
I am responsible for any balances due on my account and any other patient(s) listed below.

If patient is not yourself, please name: _____ _____

_____ _____

_____ _____

Signature of patient, parent, or authorized representative _____Date ____/____/_____