FINANCIAL POLICY

Welcome to the Northeast Colorado Family Medicine Assoc., P.C. Please take a few minutes to review the following information prior to your appointment.

We hope you understand that our financial policies are established to assure the financial resources needed to maintain this medical office for all of our patients. We will work with you to ensure that your medical care does not become a financial burden.

- **Charges for medical services are due and payable at the time of service. We accept cash, personal checks, Visa, and MasterCard credit cards for payment of your account.**

About Health Insurance:

- Your insurance policy is an agreement between you and your insurance company. Our relationship is with you, and not your insurance company. Therefore, all charges are ultimately **your** responsibility, regardless of your insurance status.

- IT IS THE PATIENTS RESPONSIBILITY TO KNOW THEIR BENEFITS. Your policy may apply services towards a Deductible, or not cover them at all. Therefore, if you have questions regarding your benefits, it is in your best interest to contact your carrier before services are rendered.

If you have health insurance with which we participate:

- We will bill your insurance claim for you
- **We expect any required co-payment/deductible/co-insurance at the time of service.**

If we do not participate with your insurance plan:

- Filing your claim will be your responsibility.

Accounts that are 30 days past due are subject to collection proceedings, unless prior arrangements have been made with our business office.

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Please sign and date this form. Return to the receptionist and she will provide you a copy for your reference. I, _____, authorize Northeast Colorado Family Medicine Assoc., P.C. to furnish diagnosis and records of any treatment or examination rendered to me or my child during the period of such care to any or all of the following: Physicians involved in my treatment ; Medicare, my insurance carrier(s); or my employer(only for work related injuries). I authorize and request my insurance company to pay directly to Northeast Colorado Family Medicine Assoc., P.C. insurance benefits, otherwise payable to me. I understand that my insurance carrier my pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that I will be charged an $8.00/month statement charge if more than one statement is printed. Effective 04/01/2009.

I authorize Northeast Colorado Family Medicine Assoc., P.C. to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I have read and understood the above.

Date: _____ Signature: _____ Witness (For office use only): _____