

*FAMILY DOCTORS OF GREEN VALLEY*

**Financial Policy**

Thank you for choosing Family Doctors of Green Valley (FDOGV) as your healthcare provider. We are committed to your treatment being successful. Our Billing Department will work hard to make sure your claims are filed accurately and promptly. Please understand that insurance reimbursement can be a long and difficult process. Therefore, it is important to understand YOUR insurance policy and coverage.

Please **READ** and **INITIAL** all of the lines:

- \_\_\_\_\_ FDOGV will submit a claim to your insurance company. If we are not contracted providers with your insurance company, we will gladly file your claims, but do require payment in full at the time of service.
- \_\_\_\_\_ All co-pays, co-insurances and/or deductibles are due at the time services are rendered. These payments are collected prior to seeing the physician.
- \_\_\_\_\_ Not all services are covered by your insurance company; please refer to your policy for clarification and verification of coverage and benefits. Fees for non-covered service are the responsibility of the patient or guarantor.
- \_\_\_\_\_ Having a primary and secondary insurance policy does not always relieve you of any balances. It is your responsibility to understand the coverage of both plans and out-of-pocket expenses.
- \_\_\_\_\_ If you have a managed care plan that requires the establishment of a primary care physician; it is your responsibility to contact the insurance company.
- \_\_\_\_\_ Fees for labs work or cultures are billed separately by the appropriate lab. FDOGV is not responsible for any outside billing facilities.
- \_\_\_\_\_ If your insurance company changes, it is your responsibility to notify FDOGV immediately so that we may bill correctly.
- \_\_\_\_\_ If your insurance company does not pay within 60 days, we reserve the right to begin billing you directly and recommend that you contact your insurance carrier to follow up on the payment status. Accounts become delinquent after 90 days and will be placed with a private collection agency and subject to a \$25 collection fee and all costs associated with the collection process.
- \_\_\_\_\_ Returned checks will be subject to a \$20 fee. Payment for the returned check amount and the fee is due within 10 days of notification received from FDOGV.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on my medical claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled, including Medicare, private insurances, and other health plans to FDOGV. The assignment will remain in effect until revoked in writing by me. A photocopy of this assignment is to be considered as valid as the original. I understand that I am fully responsible for all charges whether paid by said insurance.

I have read the financial policy, and I understand and agree with this financial policy.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient