DRAVES FAMILY PRACTICE
FINANCIAL POLICY

Please initial each item below to acknowledge that you have read and understand our office policies and procedures related to the responsibilities of the patient.

_____ If our office is not filing an insurance claim for you, payment in full is due at the time of service unless prior arrangements have been approved through our billing department.

_____ **It is your responsibility to present your insurance card to our receptionist on every visit, even if you believe there have been no changes to your plan.**

_____ Our office will bill your insurance carrier for all covered services if you are covered by a plan that we are contracted with as a participating provider. You are required to pay all co-payments at the time of your visit.

_____ If you do not present your updated insurance card or if you give us an incorrect insurance card and the claim is denied by the insurance, the patient will be responsible for any outstanding balance. **We will not re-file the claim for you.**

_____ If you fail to pay your co-pay at the time of service, a $5.00 billing charge will be added to your account.

_____ Should your insurance deny a claim due to diagnosis or coding, our office will not change the initial diagnosis or coding just so your insurance will pay. It is the patients responsibility to know your benefits and to inform the doctor of such at the time of your visit to best guarantee payment from your insurance.

_____ Billing charges in the amount of $5.00 will be added to unpaid balances over 60 days. If no payment is made on your account after four months, your account will be forwarded to our collection agency and credit bureau for further action. At this time, you will be notified by certified mail with a 30-day notice of the discontinuation of your care. Prompt payment on your account will avoid this action.

_____ It is your responsibility to keep all of your information updated with our office such as addresses, phone numbers and responsible party information where statements should be sent.

_____ **If you have lab work drawn in our office, this is a completely separate billing entity through Jefferson Regional Medical Center. Please present your insurance card to the phlebotomists at the time of your blood draw. Our office is not responsible for statements you receive from Jefferson Regional Medical Center.**

Please sign below to indicate you have read, understand and agree to all of the above financial policies.

_____ _____

Signature of Patient or Responsible Party Date: