CONSENT TO TREAT AND FINANCIAL POLICY

Thank you for choosing Northcrest Family Medicine as your health care provider. In an effort to keep patients informed about our policies, we ask that all patients **read and sign** a copy of the financial policy prior to receiving treatment. Below you will find the requirements as they pertain to **insurance billing and patient payment requirements.**

PAYMENT is expected at the time of check in. This includes all deductibles, coinsurance, and co-payments. Patients who have no insurance carrier with whom the practice has a valid contract will be responsible for all fees of service.

INSURANCE is filed for all primary carriers. Secondary or supplemental insurance is filed as courtesy. We allow 30 days for insurance processing. Please remember that it is the patient's responsibility to know the benefits/ coverage of their own individual plan.

RETURNED CHECKS will result in a $25.00 service charge. The check amount plus the service charge is to be paid within 10 days on notification. Failure to pay in full in 10 days will result in collection through the magistrate court.

STATEMENTS are sent to update patients as to the status of their account and whether the insurance company has fulfilled their obligation to you, the policy owner, to pay claims in a timely manner.

DELINQUENT ACCOUNTS are placed for collection 90 days from the date of service was rendered. Patients having financial difficulties are encouraged to discuss them with our financial counselor **before** the account has a delinquent.

NO-SHOW POLICY- We will make every effort to give you a reminder call at least 24 hours prior to your appointment; however in order to accommodate our other patients with appointments we request that you cancel at least 24 hours before your appointment. Failure to show up for your appointment without notification will result in a $35.00 fee which must be paid **before** your next appointment is scheduled.

FORM FEE - If you have forms that need to be filled out by our doctor without an appointment, there will be a $25.00 form fee that must be paid before completion of the forms.

I, hereby make assignment of all disability, medical and major medical insurance benefits payable to Northcrest Family Medicine. I understand that ***payment is expected at the time of check in*** and rendered unless prior arrangements have been made. I also, hereby make authorization for Northcrest Family Medicine to release and medical information necessary to execute an assignment of benefits. ***I understand that regardless of any insurance coverage I might have, I am personally responsible for all charges to my account.*** I further agree that in the event of non-payment, to bear the cost of collection, and/or the court cost and reasonable legal fees should be required.

By signing this form I give Northcrest Family Medicine consent for treatment and to obtain any medical records, including pharmacy history, necessary for treatment.

I have read the consent to treat and financial policy of Northcrest Family Medicine. I understand and agree to adhere to the policies as outlined.

_____ **Please Print Patient Name**

_____ **Signature of Responsible Party**

_____**Date** _____

Office Witness Signature and Date