FINANCIAL POLICY AND AGREEMENT

Patient Name: ____ Date of Birth: ________________

Last Name First Name Middle Initial

- For services outside of Foothill Family Clinic (FFC), it is your responsibility to know which facility to use. If you aren't sure, please talk to your insurance member services before scheduling.
- You agree to be financially responsible for payment of FFC's services. Cash, check, or credit cards are acceptable forms of payment for these services.
- Current insurance cards must be presented at every office visit. FFC is not responsible for filing your insurance claim, but as a courtesy we will do so. You agree to pay the remaining balance after your insurance has paid on your claim, immediately upon receipt of a statement.
- You understand that you will be responsible for any missed appointments, or any cancelled appointments, in which a 24 hour notice was not given. There will be a fee of $75 for any missed office visit/same day no show and $150 for any missed physical exam and/or office procedure.
- You understand there will be a $25.00 fee for all returned checks, electronic payments, and declined credit cards.
- You understand that your insurance may, or may not, agree to the usual, customary or reasonable charges for your local area. You understand that your benefits may not cover all services or may deny payment for services that have been approved of in advance. You agree to pay the balance remaining on your account after insurance has been processed.
- If you have a high deductible policy, or do not currently have insurance benefits, you agree to pay an estimate of charges for your office visit **in advance** and understand that other charges may apply.
- FFC has a contract with your insurance company. FFC will receive payments from your insurance company for covered services provided by your insurance benefits. You agree to pay co-payments and deductibles **at the time of service**. If co-payments are not made at the time of service, you understand that your appointment may be rescheduled and/or a $20 billing fee will be assessed.
- You agree to pay any balance remaining on your account for any reason upon receipt of a statement and you understand that when requested, you must give FFC your current address and other contact information. You understand that if you fail to pay account balances over 30 days you will be charged interest of 1 ½% per month (18% annual rate).
- If your account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, you will be responsible for a collection fee of 23%, interest, billing fees, court costs, and attorney fees. You also understand this may result in termination from the practice.
- If your account is under a contract and payments are not received by the due date on the contract a $20 late fee will be assessed. You agree to pay for all new services rendered that are not covered by your insurances at the time of service.
- If the reason for your appointment is related to a work injury or auto accident, you agree to give FFC the case number or policy number, the workman's compensation or insurance carrier's name, address or other contact information at the time of your appointment so that FFC can bill workman's compensation or the auto insurance carrier for your visit. If you do not provide this information at the time of the visit, you agree to pay all charges for your visit.

I have read and I understand Foothill Family Clinic's financial policies and I accept responsibility for the payment of any fees associated with my care or the care of the above mentioned patient.

______________________________ ______________________

Signature Date

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment of medical benefits, including medical benefits to which I am entitled to Foothill Family Clinic, LLC. This is a direct assignment of my rights and benefits. This authorization will remain in effect until cancelled by me in writing. A copy of this authorization is as valid as the original document.

I authorize the release of any medical information necessary to in order to obtain payment and I understand that I am financially responsible for all charges, late fees, interest, attorney fees and collection charges considered patient responsibility by my insurance company. I understand that if I am not insured I am responsible for the charges of all services provided to me. I authorize Foothill Family Clinic to deposit checks received by my account when made out in my name.

I authorize payment to be made on my behalf to Foothill Family Clinic for any services provided to me by my provider. I authorize my provider to release to the Health Care Financing Administration and its agents any information needed to determine my benefits.

I understand that my signature requests payment be made to pay my claim. My signature also authorizes the release of medical information necessary to pay my claim. My signature also authorizes the release of benefits payable and medical information necessary to pay any secondary insurance payer.

I have read and I understand Foothill Family Clinic's financial policies and I accept responsibility for the payment of any fees associated with my care.

______________________________ ______________________

Signature Date