A silhouette of a person and person

Description automatically generated with low confidence **BELLBROOK FAMILY PRACTICE**

**Financial Responsibility Policy**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_/\_\_\_\_/\_\_\_\_

It is the policy of Bellbrook Family Practice that all patients or their guarantors are financially responsible for all services provided by our practice.

We accept checks, credit cards, Cash, and recurring payments.

**Co-pays are required to be paid at the time of service.** If you are not able to pay your copayment, we reserve the right to reschedule your appointment. **If you are not covered by insurance, payment is due at time of service.**

**All past due balances are expected in full at time of service.** If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. If you fail to make payment as agreed upon or failure to make any payment, your account may be referred to a professional collection agency and/or attorney.

The practice asks that all patients assign all insurance company payments directly to the practice to avoid any misunderstanding regarding payment for professional services. **The patient will be responsible for any portion of his or her bill that is not covered by the insurance carrier.** If the patient is a minor or unable to sign, the responsible party/guarantor who signed the consent to treat will be responsible for any portion not covered by the insurance carrier.

If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.

If your insurance changes, please notify us immediately so we can make the appropriate change to help you receive your maximum benefits.

Before receiving services, you must verify that we are participating providers for your insurance company. In the event we are not, we will file an initial claim as a courtesy; however, payment is due in full at the time of service. It is your responsibility to verify coverage prior to your appointment.

We must emphasize that our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between yourself, your insurance company, and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.

We may accept assignment after verification of your coverage. Please be aware that some or perhaps all the services may not be covered in full by your insurance company. You are financially responsible for services not covered by your insurance company.

All patients may be required to pay a pre-service deposit or estimated copays and deductibles prior to services or amounts may be collected after services are rendered based on the current business practices of the office.

You must provide your most current billing address, all available telephone numbers, and any other important contact information, and, if any changes occur, it is your responsibility to contact the office with the updated information.

If the provider schedules a test for you, please check with your insurance to see if it needs precert BEFORE you have it done. Although we do our best to check, it is ultimately the responsibility of the patient to ensure coverage.

We will send a statement notifying you of any balance you may owe. If you have any questions, it is your responsibility to contact our billing office within thirty days after receipt of the initial statement. Note balances under ten dollars will not receive a statement and will be notified at the next appointment.

For FMLA or other disability/medical forms, payment is required prior to the forms being mailed and or submitted. If payment is not received, we will not mail this to you or submit to the appropriate facility. If you wish to pick up your forms at the office, payment can be made at that time, if not payment can be accepted over the phone. Dependent upon the information that is required on your forms, the provider may require you to be seen prior to completing the form. Please allow 7-10 business days for completion. If you are seen in an appointment specifically about the type of form needing completed, the charge for the forms will be waived.

Below are Fees associated with the practice:

$35.00 Returned check

$25.00 Missed appointment fee

$30.00 Family Medical Leave Act forms

$30.00 Disability forms

**AUTHORIZATIONS**

**| hereby authorize Bellbrook Family Practice to apply for benefits on my behalf for services given or orders made by the providers. I request that payment made from my insurance company be made directly to the practice.**

**| hereby authorize the release of any pertinent medical information to consulting physicians and medical information from consulting physicians to insurance carriers.**

**I certify that the information I have reported regarding my insurance company is correct. Either my insurance company or I may revoke this authorization at any time in writing.**

**By signing below, I do hereby understand and agree with the financial policy and authorizations of Bellbrook Family Practice.**

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Signature of responsible party/guarantor Date

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Relationship to patient