FINANCIAL POLICY

We are committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines.

- I agree to furnish ***Truesdale Medical Center*** with a copy of my current health insurance card(s). I also agree to provide an explanation of benefits and/or claim form(s) from my insurance company, when applicable.
- I authorize the release of medical information necessary to process my insurance claim and I assign insurance benefits to ***Truesdale Medical Center*** for services provided to me by ***Truesdale Medical Center*** heath care providers.
- I understand that I will be responsible for payment of any deductible and co-payment/ co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service, as required by my insurance company before being seen by a ***Truesdale Medical Center*** heath care provider.
- I agree that I will be responsible for balances applied to my account that are not covered by my health insurance plan.
- I understand that my account will be charged $75 when a check I presented for payment is returned and marked "non-sufficient funds" (NSF). Returned checks over $500 will be assessed a fee of 10% of the amount of the check.
- I understand that ***Truesdale Medical Center*** will bill my health insurance company and will refund any overpayment on my account to the appropriate party (i.e., insurance company, patient).
- I understand that ***Truesdale Medical Center*** allows 30 days for the processing of my claim by the insurance company. In the event the practice does not receive reimbursement within 45 days, they will contact my insurance company regarding the claim; I will be notified if they do not receive a response.
- In the event I am unable to pay my responsibility in full, I will contact the office to discuss financial arrangements.
- Uninsured patients will pay a $100 per office consultation plus any additional charges that may be included in your visit.
- If you plan to pay privately for your services, please be advised that it is the policy of ***Truesdale Medical Center*** to collect payment in full at the time of service. If you are unable to make payment in full at the time of service, your appointment will be rescheduled to a more convenient time.
- I accept full financial responsibility for all charges, insurance balances, self-pay balances and other fees that may not be covered by my medical plan.
- I consent to the release of my protected healthcare information to credit card companies, banks and financing companies in the event a charge is disputed.

I acknowledge that I have received a copy of this financial policy. I agree to read this document and comply with the terms set forth for services rendered by ***Truesdale Medical Center.***

_____ _____

Patient Signature (Guarantor) Date

_____ _____

Witness Date