

CFPG Financial Policy

Please Print

Patient Information

Patient Name: _____ Birth Date: _____ Social: _____

Consent For Treatment

Welcome to our medical practice. We are committed to providing you with the best possible care and services. If you have insurance, we are anxious to help you to receive your maximum plan benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Balances owed for services rendered are due at the time of service and are rendered unless payment arrangements have been preapproved by our billing department. Copays will be collected the day of your appointment. We accept cash, checks, Visa, Mastercard and debit cards. We will file a claim for your primary insurance. Patient balances greater than 30-days old may be charged a monthly late fee of \$5.00 with each patient statement.

Please realize that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that specific contract.
2. We have established our charges based on the actual value of the services. We do, however, provided significant adjustments to those services with many insurance companies.
3. Not all services rendered are a covered benefit with all insurance company contracts that you or your employer may have chosen. It is important for you to have an understanding of the benefits and regulations associated with your health plan.

We must emphasize that as a health care provider, our relationship is with you, not your insurance company. Follow up on outstanding claims with your insurance company may require your intervention; and we appreciate your working with us in that regard. We realize that temporary financial problems may affect timely payment of your account. However, if such a problem should occur, we expect you to contact us promptly for assistance. If you have questions about the information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. WE ARE HERE TO TRY TO HELP YOU.

Policies Related To Medicare and Medicare Supplement Insurance

We are a participating provider with the Medicare Part B program; and as such are obligated to write off the difference between Medicare's allowed amount and our charge. Medicare pays 80% of that allowed amount to us directly. The 20% copay and annual deductible is the patient responsibility by federal law.

We do not manually file claims to your Medicare supplement. If Medicare transmits your supplemental information for payment to your insurance company, we will allow 30 days for payment. After 30 days, payment to our office and collection from your supplemental insurer will be your responsibility.

Policies of Contracted Managed Care Companies

In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs. While we are pleased to be able to provide this service to you, it is impossible for us to keep track of all the individual requirements of the many various plans. Each one has different stipulations regarding what services may be rendered and, even more importantly, where and who those services may be performed by. Even within the same insurance company, the plans differ depending upon what types of contracts you or your employer requested.

Providing quality medical care for our patients is our primary concern. We will provide that care within your contract guidelines, but we expect you to contact your plan and to actively participate in knowing your plan regulations as services are rendered. **If a treatment authorization is required by your plan, please be sure that our office is in receipt of that authorization PRIOR to your appointment or your appointment may require rescheduling.**

If you do not inform us of any special requirements in your contract, and we subsequently order services such as lab work, medical equipment, outpatient diagnostic services, hospitalization, or any other services recommended by your physician that are not covered, we or the selected medical facility will have no alternative but to bill you directly for those charges. Payment for those charges is your responsibility.

With your cooperation and direction you should be able to receive all the benefits offered to you, and we will be able to concentrate on caring for your medical needs.

Beneficiary Signature: _____ Date: _____

Authorized Representative Signature (if applicable): _____ Date: _____