

PHYSICIANS' ALLIANCE, LTD

Financial Policy

Thank you for choosing ELIZABETHTOWN FAMILY HEALTH CENTER as your healthcare provider. It is our goal to meet our patients' needs and address all concerns effectively.

An area of primary concern for all patients is the financial policies of the practice, especially those pertaining to insurance billing and payment requirements. In an effort to keep patients informed about such policies, we ask that all patients read and sign a copy of our financial policy.

As in all aspects of healthcare today, the greater role the patient assumes, the higher the degree of satisfaction achieved. For that reason, we expect our patients to take an active role in their healthcare management, including the area of finances.

PAYMENT is expected at the time services are given. This includes all deductibles, co-insurance and co-payments. Patients who have insurance carrier with whom the practice has a valid contract will be responsible for all fees as outlined in the patients' contract agreement.

CLAIMS are filed only for insurance carriers with whom we have a contract agreement.

RETURNED CHECKS will result in a \$20.00 service charge. The check amount plus the service charge is to be paid within 10 days of notification. Failure to pay in full in 10 days will result in collection through the magistrate court.

DELINQUENT ACCOUNTS are placed for collection 90 days from the date the service was provided. Patients having financial difficulties are encouraged to discuss them with our financial counselor or office manager before the account becomes delinquent.

PLEASE indicate how you plan to pay for your services:

_____ Cash _____ Check _____ Visa _____ MC _____ Discover _____ AMEX

I have read the Financial Policy of Physicians' Alliance, LTD / **Elizabethtown Family Health Center**.

I understand and agree to adhere to the policies as outlined.

Print Name

MRN# _____

Signature of Responsible Party

Date

Witness

Date

*This form is to be updated on a yearly basis.