Financial Policy

Patient Name: ____ DOB: ___________________

Effective November 6, 2019

Thank you for choosing Lakewood Family Health as your health care provider. **Please carefully read and initial by each statement and sign below.** This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager or billing department will be glad to discuss these policies with you.

1. _______ I understand that if I do not have my insurance card, referral, and/or co-payments, that my appointment may be rescheduled until such time that I can provide the required documents or payments.
2. ______ I understand that Lakewood Family Health will collect all copayments at the time of visit and any procedure deductibles and coinsurance up to an amount equal to payment in full for the planned procedure code. Payment in full and expected coinsurance payment responsibility are determined by the anticipated billing code(s), details of your insurance policy, and agreement between your insurance company and Lakewood Family Health. Lakewood Family Health may bill you directly for any charges not covered in full by insurance. Any overpayment to your account will be refunded to you at your request after payment and/or remittance has been received from your insurance company.
3. _______ I understand that a **$40** service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order, or cash.)
4. _______ I understand that if I am unable to make a scheduled appointment, I need to contact Lakewood Family Health at least **24** hours before my scheduled appointment time. A **$25** fee WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS
5. ______ I understand that if my account is not paid in full within 90 days of a statement date, no additional appointments will be made for delinquent accounts until they are brought current. A **$15** fee will be collected for all past due accounts > 90 days.
6. ______ Lakewood Family Health will allow 60 days from the date of filing for my insurance company to process or pay a claim. It is my responsibility to provide my insurance company with requested information needed to process a claim for services. It is also my responsibility to notify Lakewood Family Health if there is any change in my insurance coverage, residence, or phone number. ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS.

I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by the attending healthcare provider.

Signature of Responsible Party: ____________________________________ Date: _____________

ASSIGNMENT OF BENEFITS

We require insured patients to complete assignment of benefits authorizing insurance to remit payment to healthcare provider's office.

I hereby assign all medical and /or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to: Lakewood Family Health. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges not reimbursed by insurance company. I hereby authorize said assignee to release all medical information necessary to secure the payment.

Signature of Responsible Party: ____________________________________ Date: _____________

PROFESSIONAL CONDUCT BEHAVIOR EXPECTATIONS

Lakewood Family Health believes that all patients are treated with the utmost respect. We have a no tolerance policy for unprofessional behavior. Using intimidating, threatening, vulgar, demeaning, disrespectful, discourteous and/or abusive language and/or behaviors in the presence of office staff or towards other patients will lead to immediate dismissal from the practice. I agree to abide by the Professional Conduct Behavior Expectations.

Signature of Responsible Party: ____________________________________ Date: _____________