Financial Policy – Paul W John MD 2018

Please initial by each number:

__________ 1. Copay, deductibles and non-covered services are to be paid at the time of service.

__________ 2. I understand that it is my responsibility to verify if my well-check (annual physical) benefit schedule is once per calendar year or once every 365 days.

__________ 3. I understand that my signature is valid for the purposes of filing my insurance and I authorize payment of benefits from my insurance company to Paul W. John MD PA.

__________ 4. **Claims Submission**. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility, whether your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

__________ 5. **Non-covered services**. Please be aware that some of the services you receive may be considered non-covered by Medicare and other insurers. These insurance company decisions are not in our control. The patient will be billed for any non-covered services.

__________ 6. **Patient Billing**. Our secure, HIPAA compliant software can hold your Credit Card information securely. We require a credit card of file to cover miscellaneous insurance balances and "NO SHOW" appointment fees. If you don't keep a credit card on file, we require a $100 deposit be made today. Receipts for all transactions will be mailed to your address promptly!

__________ 7. **Collections.** If your account is past due and if a valid payment arrangement is not made or kept, your account will be sent to an OUTSIDE COLLECTION AGENCY and a 30% fee will be added to the account. In most cases, once sent to collections the family is dismissed from the practice. To keep this from happening, please pay your bills upon receipt or call to set up payment arrangements. We understand financial hardships may prevent you from paying your bill from time to time, but we cannot work with you if we don't hear from you. IT IS YOUR RESPONSIBILITY TO CONTACT OUR OFFICE ABOUT BALANCES ON YOUR ACCOUNT.

__________ 8. **Missed Appointments**. Our software sends Email and Text Appointment Reminders 5 days and 2 days prior to your appointment day. This is done as a courtesy. (We are not responsible for changed email addresses and text settings you have with your phone provider.) Please help us by confirming your appointment when you receive these reminders. We have a **24-hour cancellation** policy. Any appointment not cancelled at least 24 hours prior and "no shows" are subject to a $35 fee. ($50 fee for physicals.) These charges will be charged to your credit card on file if our office is unable to fill your appointment time.

__________ 9. **Method of Payment**. Our office accepts all major credit cards and cash. **No checks.**

By signing below, I agree that I am responsible for balances remaining on the account. I have read and understand the payment policy and agree to abide by its guidelines.

______________________________	______________________	____________
Signature	Relationship to Patient	Date
______________________________	______________________	
Printed Name	Name of Patient	