THRONEBERRY FAMILY CLINIC

FINANCIAL AND APPOINTMENT POLICY

All patients with or without insurance are required to pay at the time of service. If I do not have my insurance card, I understand that I may be asked to reschedule. We will accept Cash, Mastercard, Visa, or Pre-Approved personal Checks. If you have a copay, this will be collected at the front window. All other deductible/coins that is your responsibility will be collected when you check out. We will calculate these charges to the best of our ability, but after filing your claim with the insurance company if there is a balance due, we will send you a statement or collect at your next visit. If there is a refund due, we will either refund you or apply it to your account.

I hereby authorize the release of any medical information related to claims for benefits submitted on behalf of myself or my dependents. I authorize all my rights, title and interest to my medical reimbursement benefits under my insurance policy to Throneberry Family Clinic for services rendered. I understand this authorization shall remain valid until written notice is given by my revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by my insurance.

I agree it is my responsibility to know and understand my insurance policy regarding referrals, hospital and test pre-certifications, deductible, coinsurance and copayments. It is the policy of Throneberry Family Clinic to help the patient in obtaining full benefits from your insurance company. However, it is the patient responsibility providing the insurance company with all information requested in a prompt manner.

Our appointment policy is as follows. We will confirm appointments a day in advance by calling the contact number given us. This is done as a courtesy to you. Cancelling or rescheduling of appointments is your responsibility. We have the right to charge for missed appointments as we deem necessary. This fee is not covered by your insurance company, it would need paid before another appointment can be made.

If you have any questions concerning these policies, please call the office and ask to speak to the Office Manager.

I acknowledge that I have read and understand the policies stated above.

Patient Name:____

Signature(parent if minor):________________________________ Date:______________