FAMILY FIRST
WOMEN & CHILDREN'S HEALTHCARE
MEDICAL AESTHETICS

Practice Financial Policy

It is the aim of Family First to have a Practice Financial Policy that clearly outlines patient and practice responsibilities. We are committed to providing our patients with the best possible medical care and minimizing administrative costs. This Policy has been established with these objectives in mind and to avoid misunderstanding or disagreement concerning payment for professional services.

REGULAR WELL VISITS:

1. **We require routine wellness visits for every patient**. Infants and children under age 2 must be seen for regularly scheduled visits as recommended by the physician. All children (age 2 and older) and adults must have routine well visits annually. Regular well visits are a vital part of good medical care for our patients. Failure to comply with this policy may result in dismissal from the practice for non-compliance.
2. Some insurance plans do not cover wellness visits. Also, some insurance plans limit coverage for visits by age, and/or limit coverage frequency. If your insurance does not cover these wellness visits, payment for services will be your responsibility.

Initials _____

FORMS:

1. All medical forms (including, but not limited to, school physicals, daycare physicals, camp or sports forms, FMLA, insurance forms) must be presented at time of visit with appropriate information entered. Requests for forms not at the time of visit will require a $25 service fee payable by check or cash prior to the form.
2. Dependent upon the complexity of the form requested and/or length of time since most recent visit, a separate office visit may be required.

Initials _____

INSURANCE PLANS:

1. It is your responsibility to keep us updated with your correct insurance information. If the insurance company you designate is incorrect, or if you fail to provide current information at the time of service, you will be responsible for payment for services and to submit the charges to the correct insurance company for reimbursement yourself.
2. Family First has preferred provider contracts with several major insurance companies. While we do our best to remind you to verify coverage, it is your responsibility to determine if our practice has an in-network contract with ***your*** insurance company prior to obtaining service. Due to the many different insurance products, our staff cannot guarantee your eligibility and coverage.
3. If we are not contracted with your insurance company, you may be asked to pay in full at the time of service. For your convenience, we may submit a claim on your behalf to your insurance company for reimbursement. If the insurance company issues payment we will credit your account or issue a credit.
4. All co-pays are due at the time of service. Any additional financial portion that is the "member's responsibility" such as a deductible or a non-covered percentage may be collected at the time of service. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time (60 days), you will be billed. If we later receive payment from your insurer, we will refund any overpayment to you or issue a credit to your account.

Initials _____

THIRD PARTY BILLING:

1. We do not bill third parties for services. We will submit claims only to your primary and secondary medical insurance carriers. Otherwise, we request payment in full at the time of service and you may submit your receipt for reimbursement to the applicable third party.

Initials _____

DIVORCE DECREE:

1. We are not a party to any divorce decrees. The responsibility for payment and the presentation of active insurance cards at the time of service is the responsibility of the accompanying adult.

Initials _____

PAYMENTS:

1. Co-pays are due at the time of service. Payment for services without insurance coverage ("Self-Pay") are due at the time of service.
2. Any outstanding balances are due upon receipt of the statement. The second and each subsequent statement will be assessed a **$5** rebilling fee. It is your responsibility to contact us in a timely fashion with questions regarding your account. All balances reaching **45** days past due may be sent to a collection agency. Should your account be sent to a third-party collection agency and/or attorney to obtain judgment or otherwise satisfy payment of this account, all collection costs, attorney fees, filing fees, interest, and court costs will be added to the total amount due.

Initials _____

RETURNED CHECKS:

1. Checks returned to us by the bank will be assessed a $35 returned check fee, in addition to the original amount of the check. You will have 10 days to clear up the outstanding check.
2. If you have a returned check, we may require payment by cash or money order for all future visits.

Initials _____

MISSED APPOINTMENTS:

1. We understand there will be times when a scheduled appointment cannot be kept. If you need to cancel or reschedule an appointment, we request that you notify our office 24 hours in advance. If your appointment is made for "same day" and you find yourself unable to keep it, please call to cancel with a minimum of notice of one hour.
2. If you do not cancel by the specified deadlines, a **$50** missed appointment ("No Show") fee may be added to your account. This fee is not payable by your insurance company and will be your responsibility to pay at or before your next appointment.
3. Multiple missed ("No-Show") appointments for either an individual patient or a family may result in dismissal from the practice.
4. A missed ("No-Show") first appointment for a new patient may not be rescheduled.

Initials _____

RELEASE OF MEDICAL RECORDS:

1. Copying, printing, mailing and/or faxing medical records require staff time and expense. A fee for medical records may be assessed. You must sign a release of medical records prior to the release of your records.

Initials _____

I have read and fully understand the policies of Family First, and agree to the terms. I also understand that the terms of these practice and financial policies may be amended by the practice at any time without prior notification.

Signature: _____ Date: _____

Patient/Parent/Guardian/Legal Representative