Trinity Family Physicians

Financial and Insurance Policy

Thank you for choosing Trinity Family Physicians as your health care provider. As part of our services, we require you read and sign the following financial policy prior to services being rendered. Patient or responsible party must complete our information and insurance form before seeing our physicians or nurse practitioner.

*__Payments:__ Full payment, co-payment, co-insurances and / or deductibles are due at the time services are rendered. Payment methods are: Cash, Check, and credit card. If you do not have your fees with you at the time of services we have the right to reschedule your appointment. Please bring your insurance card, driver's license and your portion to pay with you at every visit. If your account becomes delinquent requiring a referral to collections then you will be responsible for all fees incurred.

_____Initials

***Return checks:** A $50.00 service charge will be charged to your account for returned checks. Returned checks will not be re-deposited. All balances must be paid in cash or by credit card. One attempt will be made to collect this debt from the patient, if not collected within 5 days of the returned check; the account will be turned over to a collection agency. We request a copy of your driver's license for our records for verification.

_____Initials

***Office Policy:** Per our contract with each insurance policy, it is your responsibility to know your benefits. Insurance is billed as a courtesy to our patients; however, the patient is the final responsible party. Your insurance company does not guarantee your benefits until the claim is filed. If your insurance has not paid within 60 days you will be responsible for the balance. Your insurance will send you an explanation of benefits that explains what they have paid to our office. If you do not agree with their payment, please contact the insurance company directly.

_____Initials

***Appointment Cancellation Policy:** A $60.00 fee will be charged for scheduled appointments cancelled without 24 hours prior notice or if you walk out prior to being seen. Patient will also be charged for failure to show up for a scheduled appointment. If you have more than two missed no show appointments you may be dismissed from our practice.

_____Initials

***Minor Patients (under the age of 18):** The adult accompanying a minor (patient/guardian) is responsible for full payment at the time of service. For unaccompanied minors, payment arrangements need to be made in ADVANCE and we must have parents or guardians written permission along with a copy of their photo I.D. prior to treatment of a minor.

_____Initials

***All Medicare Patients:** We will bill Medicare as well as secondary insurance. If you have Medicaid as a secondary insurance we will not be able to see you. If payment is not received from your secondary insurance within 60 days, you will be notified that there is an outstanding balance due. You must then contact your secondary insurance to receive reimbursement for any fees paid directly to our office. **_____Initials**

***PCP Selection:** It is your responsibility to make sure that if your insurance requires a PCP to be selected on your insurance policy that you have it switched over to one of our providers prior to your each visit and make sure our provider is the effective and current provider for you. If this is not done or not effective prior to your appointment you understand that you will be financially responsible for that visit at the time of service. This is your insurance company's policy and not ours.

_____Initials

***Policy on Physical Exams:** We do encourage physicals (well-visits) at separate visits during the month of your birthday each year. We recommend all patients to do this for preventative care and health maintenance. If you are here for a medical complaint then this visit is NOT a physical and will be billed accordingly.

_____Initials

Please realize that:

1. Your insurance is a contract between you, your employer and the insurance company.
2. You are responsible for all charges that are denied / not covered by your insurance company. Procedures / services performed by our physicians, nurse practitioner or nurses may not be covered under your insurance plan.
3. Although we verify your coverage through your insurance company with each and every patient, verification of benefits is not a guarantee of payment from your insurance company. We request that you present a copy of your insurance card for our records that is being utilized.
4. If you are sent outside of the office for additional testing such as lab work or imaging, that facility will file your insurance for you. If you have questions regarding billing or claim payment, call the facility directly. We do not have information regarding billing from outside this office.

Print Patient's Name: _____

Date:_____

Signature of Patient or Legal Guardian:_____

Print Name of Parent / Legal Guardian: _____

Please provide a credit card or debit card for our records that may be used to cover cancellation or no show fees in the office.

Name on card:_____

Credit Card Number: _____

Expiration Date:_____/_____ CVV:_____

I have read and understand my card can potentially be charged if I fail to show up to an appointment or cancel within 24 hours of my scheduled appointment.

Print Patient's Name: _____Date:_____

Signature of Patient or Legal Guardian: _____

Print Name of Parent / Legal Guardian: _____