



**SOUTHERN FAMILY MEDICINE  
PATIENT FINANCIAL POLICIES**

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies. Many of our patients have health insurance or other medical benefits that are provided through a private insurance company, a government program, a health maintenance organization (or “HMO”), a preferred provider organization (or “PPO”), or other similar health plan. In this policy, we use the term “health plan” to refer to any and all of those different sources of benefits.

**If you do not have any medical benefits...** Full payment is due at the time we provide services, unless we have agreed to different arrangements in advance and in writing.

**If you have medical benefits, but we do not participate in your health plan...** We require you to pay in full at the time we provide services. We may assist you by submitting a claim to your health plan on an “unassigned” basis, which means that the health plan may later reimburse you. The amount of the reimbursement, if any, will be determined by your health plan based on your benefits. We are not responsible if the reimbursement is less than the amount we charged you for the services.

**If you have medical benefits through a health plan in which we participate...** We require you to pay any applicable co-payment when you arrive for each visit. As a service to you, we will submit a claim to your health plan if you assign your benefits to us – in other words, if you agree to have your health plan pay us directly. If your health plan does not pay us within a reasonable time period, we will look to you for payment. If you pay us and we later receive a check from your health plan, we will refund any overpayment to you.

**If you have medical benefits, but your health plan determines a service we provide is “not covered” by your benefits...** You will be responsible for the full cost of the service. If your health plan pays part of the cost, we may require you to pay the balance. Payment will be due upon your receipt of our bill.

**Please note that we reserve the right to...**

- Require patients to pay a deposit at the time of scheduling certain high-cost services.
- Submit any patient account with a balance older than 30 days to a collection agency, and to require the patient to pay all legal fees and collection costs we incur.
- Charge a fee of \$50.00 for each returned check.
- Charge a fee for services that do not directly involve patient care, such as preparing workers compensation forms, disability forms and written correspondence for patients.
- Charge an office visit fee for failure to show for an appointment or failure to cancel within 24 hours
- Charge a rebilling fee for any balances not paid within 30 days
- Amend these policies from time to time.

**It is your responsibility to understand the benefits provided by your health plan.**



**We accept local checks (with a photo ID), MasterCard and Visa.**



**PATIENT ACKNOWLEDGMENT**

**I have read and understand Southern Family Medicine’s financial policies set forth above, and I agree to be bound by such policies, as they may be amended from time to time.**

\_\_\_\_\_  
Signature of patient (or personal representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of patient