Stay Healthy Keep Smiling

Financial Policy and Patient Consent Form – Effective March 30, 2016

Family Medical Wellness Center, LLC ("FMWC") recognizes the need for a clear understanding between patient and medical provider regarding protected health information and financial arrangements for healthcare. The following information is provided to avoid any misunderstanding concerning protected health information and payment for professional services. For the safety and protection of our patients and **FMWC**, patients are required to present a valid form of identification upon check-in prior to treatment.

We realize that the cost of healthcare is a concern for our patients and we are available to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our relationship. The following is a statement of our Financial Policy, which you must read, agree to, and sign prior to treatment. Carefully review the following information and please ask if you have any questions about our fees, policies, or your responsibilities.

Provide Accurate Information:
You have a responsibility to provide accurate and complete information about your health history, mailing address, health insurance and other billing information. If any information changes-name, address, phone number, email, insurance coverage, etc.- you must inform this practice immediately. Insurance denials or billing errors due to patient supplied information will result in the immediate transfer of the account balance to the patient's immediate financial responsibility.

Know Your Insurance Coverage and Benefits:
Your health insurance coverage is a contract between you and your health insurance carrier. Patients are responsible for understanding their health insurance coverage(s) and benefits. There may be limitations and exclusions to coverage. **You are responsible for any charges not covered by your plan**.

Insurance Accounts:
We ask that you present your insurance card at every visit. If you fail to provide us with the correct insurance information at each visit a waiver must be signed and you may be responsible for payment for all services provided.

- Co-payments are due at the time of service, as it is a requirement placed on you by your insurance carrier. Please help us by paying your co-payment at each visit.
- If your insurance company requires you to pick a Primary Care Physician (PCP) one of our physicians must be the PCP listed on your insurance card.
- We will file claims to the insurance companies we contract with, provided that you authorize the "assignment of benefits" for payment directly to our practice. For plans that we participate in, the practice will accept payment based on contractual agreements. You agree to pay any portion of charges not covered by insurance.
- For insurance plans we do not contract with, we will file claims as a courtesy, provided that you authorize the "assignment of benefits" for payment directly to our practice. If your insurance does not pay within 60 days, you will be responsible to pay the balance of unpaid charges and follow-up with your insurance directly.

Self-pay Accounts:
Self-pay accounts are patients without insurance coverage or who are unable to provide us with valid insurance information. If a patient is able to provide valid insurance information within 30 days of the original date of service a claim will be filed with the insurance carrier. If the insurance carrier issues payment for services rendered the patient will be issued a refund based upon the insurance payment. Self-pay patients are responsible for paying 100% of charges at the time services are rendered.

Worker's Compensation and Motor Vehicle Accident:
In the case of a worker's compensation injury, motor vehicle accident and/or other third party liability you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier PRIOR to your visit. Failure to provide worker's compensation, motor vehicle accident and/or other third party liability information within 30 days of the date of service may result in any unpaid balances transferring to patient responsibility. Payment for any services that we provide will ultimately be your responsibility if not paid promptly by another party.

Statements:
A statement will be sent to you once a balance becomes patient responsibility and will continue every 30 days thereafter. Unless you notify our office within 30 days of receiving your statement that you dispute the validity of the balance or any portion thereof, we will assume the balance is correct and valid.

Collection of Outstanding Balances:
All outstanding balances shall be due within 14 days unless prior monthly payment arrangements have been made in writing. Balances that remain outstanding after 90 days or more may be referred to an outside collection agency/attorney and may result in termination of medical care by FMWC. If your account is referred to an outside collection agency/attorney you may be responsible for paying any incurred collection agency/attorney's fees. **Any Invoices not paid in 90 days you will be required to pay an additional Past Due Fee of $25.00**.

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Types of Payments:
Our practice accepts Debit, Visa, Mastercard, American Express, and Discover. Cash, check or money orders are also acceptable methods of payment. **If your check is dishonored (returned for non-sufficient funds) you will be required to pay an additional fee of $25.00.**

Convenience Fee:
Patients who desire Family Medical Wellness Center (FMWC) to draw blood understand that they will be charged a fifteen dollars **($15.00) convenience fee**. It is understood that this convenience fee is not for the drawing and handling of your blood and that it is not a "Covered Service" by your insurance company. Therefore, this fee is not reimbursable by your insurance company.

Missed Appointments:
It is important that you appear for all scheduled appointments. By way of courtesy, we usually (but need not) call to confirm your appointment a day or two before the scheduled visit. If speaking to you is not possible for any reason, we attempt to leave a reminder message on an answering machine or voice mail. Your failure to appear for a scheduled appointment or to cancel an appointment at least 24 hours prior to the visit may result in a missed appointment fee. This policy is aimed at minimizing waiting time and ensuring availability of medical care for all of our patients. We recognize the fact that there may be circumstances which may not permit you to give 24 hours prior notice but such occurrences are exceptionally rare and shall be considered on a case by case basis. **You will be required to pay an additional fee of $25.00 for missed appointments or No Show.**

Treatment of Minors:
The parent(s) or legal guardian(s) is responsible for full payment and will receive the billing statements. A signed release will be required to treat unaccompanied minors.

Miscellaneous Fees:
Certain services (e.g. family conferences, completing forms, producing narrative reports, personal letters, etc) may entail additional fees not covered by insurance. Payment in full is expected at the time such services are rendered. Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of service. Our office will not bill any other personal party.

CREDIT CARD ON FILE POLICY

At Family Medical Wellness Center, LLC we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Without this authorization, a deposit of $100 for each visit will be required from each patient.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I authorize Family Medical Wellness Center, LLC to charge the portion of my bill that is my financial responsibility to my credit or debit card:

I (we), the undersigned, authorize and request Family Medical Wellness Center, LLC to charge my credit card for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Family Medical Wellness Center, LLC

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Family Medical Wellness Center, LLC in writing and the account must be in good standing.

_____ _____
Patient Name (Please Print) Patient Date of Birth

_____ _____
Signature (Insured / Guardian) Date