GONZAGA FAMILY HEALTH

Financial/Office Policies

Patient Name: Patient Date of Birth:

Insurance, Co-Payments

In accordance with my insurance contract, I understand that all co-payments are due at the time of service.

Deductibles

If my insurance deductible has not been met, I understand that the outstanding deductible amounts may be collected at the time of service and at the time that interventional procedures are scheduled.

Co-Insurance

I understand that co-insurance amounts may be collected at the time of service and/or at the time that the interventional procedures are scheduled.

Self-Pay Patients

If I have no insurance coverage, or if GFH is unable to verify current insurance coverage, I understand that full payment is expected at the time of service and/or at the time of the interventional procedures. If I do obtain insurance, it is my responsibility to supply that insurance card to the office at the time of service.

Motor Vehicle Accident Patients

It is the policy of this office to bill your MNA carrier until your Personal Injury Protection is expired or exhausted, whichever comes first. Once PIP coverage is no longer available, your account will be switched to your private/public insurance and all balances will become your responsibility. We will not accept a letter of protection from your attorney in lieu of billing your insurance. If you do not have medical insurance, you will become a cash patient (see “Self-Pay Patients”).

Worker’s Compensation

It is the policy of this office to receive written documentation of worker’s compensation coverage. We will bill your employer until coverage is expired or exhausted, whichever comes first. Once PIP coverage is no longer available, your account will be switched to your private/public insurance and all balances will become your responsibility. We will not accept a letter of protection from your attorney in lieu of billing your insurance. . If you do not have medical insurance, you will become a cash patient (see “Self-Pay Patients”).

Secondary Insurance

I understand that Gonzaga Family Health will file a claim with my secondary insurance as a courtesy, but I am fully responsible for all secondary insurance amounts left unpaid by that secondary insurance.

Refund Policy

Refunds will be paid as soon as a complete insurance reimbursement for all medical services on the account have been received.

Verification of Benefits and Non-Covered Services

I understand that some services may not be covered by my insurance policy. Gonzaga Family Health will attempt to assist me in verifying whether a services is covered by my plan; however, if the carrier denies my services as non-covered, I understand that I am financially responsible for the denied services.

Payment Agreements

Payment agreements will be on an as-needed basis, determined for each patient individually, and based on balance and patient requirements. All payment agreements must be approved through the billing manager. If you refuse to sign a payment agreement, then you may not be seen and will be considered discharged from the practice.

Conclusion

I understand that once an account is referred to an outside agency for collections, no further appointments may be scheduled with a provider at Gonzaga Family Health. If my account is placed into collections, I am responsible for all collection and interest costs.

Cancellations and No-Show Appointments

We ask that you provide at least 24 hours' notice for appointments you need to cancel or reschedule. If you no-show more than 3 times for an appointment, you may be discharged from the practice. If you are 10 minutes late or more for a scheduled appointment, your appointment may be rescheduled. We will make every effort to reschedule you that same day as close to your original appointment as possible, but this depends on the total number of patients scheduled that day.

Returned Checks

Returned checks will be subjected to a $50.00 returned check fee.

Prescription Pick-up

I understand that any refill requests for prescriptions will take at least 48 hours to process. This means I understand that I will need to contact the office at least 3 days before my prescription is empty. I give permission to the following people to pick up prescriptions for me:

Person's Name:	Relationship:
Person's Name:	Relationship:

Authorization for Treatment and Financial Agreement

I authorize treatment of myself or the person listed above to receive any treatment deemed medically necessary or necessary for the diagnosis and/or treatment of the patient. I agree to pay all fees and charges for such treatment promptly upon presentation of the statement unless prior credit agreements have been agreed to and signed. Although this office may assist me in filing an insurance claim, I understand that I am fully responsible for the balance and I agree that I will not delay payment because of any pending insurance claim/s. In the event legal action should become necessary to collect an unpaid balance, I agree to pay all attorney's fees or other costs incurred that the court determines.

Patient/Responsible Party Signature **Relationship to Patient** **Date**