

TRI COUNTY INTERNAL MEDICINE

FINANCIAL POLICY

We are committed to meeting your healthcare needs. Our goal is to keep your insurance and other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, please follow these guidelines:

1. **All co-payments, coinsurance and deductible** amounts are due at the time of service as required by your insurance company. If your insurance company does not respond within 60 days, you are responsible for the remaining balance. Your insurance benefit is a contract between you and your insurance company. We are not party to that contract. Please help us serve you better by knowing your insurance benefits. *Make sure to select one of our Doctors as your PCP prior to your appointment if your Insurance Plan requires a PCP.*
2. **Returned Checks.** We accept cash, Discover Card, Master Card, Visa and personal checks. However, if your check is returned from your bank for any reason, there is \$35 service fee.
3. **Billing Fee.** We will charge a \$10.00 service fee for failure to pay at the time of service.
4. **Collection of Account.** If your account is over 30 days past due, you will receive a letter stating you have 10 days to pay your balance or make arrangements with our Billing Department. If the balance remains unpaid, we will call you and may send a 2nd letter. This letter will serve as notification that we may turn your account over to a collection agency.
5. **Cancellation Policy.** We require a 4 hour advanced notice when cancelling appointments. Should you fail to give proper notice or if you miss your appointment a fee of \$25.00 will be assessed. If your appointment type requires more advanced notice you will be informed in writing of the cancellation policy.
6. **Administrative Service Fees.** A charge of \$25.00 will be required for completion of all forms and letters. This must be paid at the time of the request.
7. **Lab Services.** Our practice utilizes the services of Lab Corp, Quest & other labs. If you receive an invoice from one of these contracted labs, call the number on that invoice should you have any questions.
8. **Motor Vehicle Claims.** It is our policy that we do not file 3rd party claims. Any office visits regarding a motor vehicle accident will be self-pay transactions. We will provide an itemized receipt for your records.
9. **Workers Compensation.** We will be happy to treat you for any work-related injury provided that we are on the Panel of Physicians for your employer.

ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE:

I authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is needed for any

utilization review or quality assurance activities. I assign all medical and/or surgical benefits including major medical benefits to which I am entitled to Tri County Internal Medicine, P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I am financially responsible for any balances not covered by this assignment.

GUARANTEE OF ACCOUNT:

For services rendered by this Practice, I hereby guarantee the payment of all accounts. If the balance due is not paid and is transferred to an outside collection agency, I understand that I will be responsible for the balance due plus the collection fee of 30%.

PATIENT NAME: _____
(PRINT NAME)

DATE OF BIRTH: ____/____/____

SIGNATURE: _____ DATE: _____

Please giving consent and relationship if not the patient: _____