Tri County Internal Medicine, P.C.
Financial Policy (Revised 2/17/2025)

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 Primary Care Physician (PCP) prior to your appointment (if your Insurance Plan requires a PCP).*
2. **Returned checks.** We accept cash, American Express, Discover Card, Master Card, Visa, and personal checks. However, if you pay by check and your bank returns your check for any reason, then we will charge a $35.00 service fee to the patient.
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 that you need to pay your balance or call and make payment arrangements with our billing department. If your account is 45 days past due, you will receive a second letter stating that you have another 15 days to pay your balance or it will be sent to a collection agency. If your account is 60 days past due, and you do not respond after receiving the first two letters, then we will turn your account over to a collections agency and you will be responsible for the balance due plus the collection fee of 30%. You will have to pay the total balance plus the collection fee prior to seeing a provider at our office again.
5. **Cancellation/No Show Policy.** We require a 24-hour advance notice when cancelling appointments. We will charge you a $25.00 fee for late cancellation of or for missing a 15-minute appointment (such as a sick visit or a follow up). We will charge you a $50.00 fee for late cancellation of or for missing a 30-minute appointment (such as an annual physical, DOT physical, I and D, Mole/Wart Removal, Toenail Removal, etc.).
6. **Administrative Service Fees.** If you need any forms completed or any letters written by our office, then we will charge you a $25.00 fee. You must pay this fee at the time of the request.
7. **Lab Services.** Our practice utilizes the services of Lab Corp, Quest, Finan Templeton, and other labs. If you receive an invoice from one of these contracted labs, call the phone number on the invoice if you have any questions.
8. **Motor Vehicle Claims.** It is our policy that we do not file third-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 or illness if we are on the Panel of Physicians for your employer. If we are not on the panel, or if you do not want to file a workers compensation claim, then any office visits regarding a work-related injury or illness will be self-pay transactions.

ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE:

I hereby authorize payment of benefits otherwise payable to me to be paid directly to this practice, including major medical insurance and payment of surgical or medical benefits, but not to exceed the charges for these services. I understand that I am financially responsible for charges not covered by this assignment. _____ *(initial here)*

GUARANTEE OF ACCOUNT:

I hereby guarantee the payment of all charges for services rendered by Tri County Internal Medicine. 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 a collection fee of 30%. _____ *(initial here)*

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT SIGNATURE: _____ TODAY'S DATE: _____
(or the signature of Legal Guardian if patient is a minor or an incapacitated adult)

Name of person giving consent (if not the patient):_____

Relationship to patient: _____