Danvers dfd FAMILY DOCTORS P.C.

PATIENT FINANCIAL AGREEMENT

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable healthcare. We ask all our patients to review and sign this policy, asking questions as necessary. A copy will be provided to each patient upon request.

1. **Insurance: We** accept assignments and participate in most insurance plans. If your insurance is not a plan we participate in, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurer with any questions you may have regarding your coverage to receive the maximum benefit.
2. **Patient Payment:** All copayments and deductibles are to be paid at the time of service. This arrangement is part of your contract with your insurance company.
3. **Forms:** There is a **$15 fee** for completing FMLA, AFLAC, and disability insurance forms. This fee must be paid before the forms are completed.
4. **Registration:** All patients must comply by providing us with up-to-date patient information. This will be entered into your medical record to maintain accurate information for proper billing. We must obtain a copy of your driver's license and a current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, or your insurance changes and fail to notify us in a timely manner, you may be responsible for the claim's balance. Most insurance companies have time filing restrictions; if a claim is not received within *30 days of the date of service*, it can be rendered ineligible for payment, and you will be responsible for the balance that remains.
5. **Claims:** We will submit and assist you in any way we can to help get your claims paid. Your insurance company may not accept information from our office and may need information from you. It is your responsibility to comply with their request. Please be aware that your claim's balance is your responsibility whether your insurance company pays or not. Your insurance benefit is a contract between you and the insurance company; we are not part of that contract.
6. **Credit and Collection:** If your account is more than 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance has remained unpaid, it may be sent to a collection agency. If an account is sent to collection and it remains unresolved, it is the policy of this office to discharge the patient from the practice. You will then be notified by certified mail you have 30 days to find alternative medical care. During that 30-day period our physicians will provide emergency care and refill of your medications.
7. **Missed appointments:** Our policy is to charge **$50.00** for missed appointments not cancelled within a reasonable amount of time. If your appointment is canceled within 24 hours' notice, there will be a **$25.00** charge issued. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointments.
8. **Medical Record Release:** Our policy is that there is a **$25.00** fee for records being sent to other primary care providers if you are transferring. At that time, all balances must be paid in full.

Thank you for your understanding. Please let us know if you have questions or concerns.

I have read and understand the financial policy and agree to abide by its guidelines.

X_____ Date_____

Signature of patient or responsible party

Print Name_____