Forum Family Medicine, PC – Patient Financial Agreement

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. We have developed this payment policy to provide clear expectations about your financial responsibility for services rendered by Forum Family Medicine. Please read and initial each section and sign below. Please feel free to ask us any questions you may have and we will provide you with a copy of this agreement for your records.

1. **Insurance**. We participate in most insurance plans, including Medicare. If we are not contracted with your insurance carrier, payment in full is expected at each visit. If you are insured by a plan we are contracted with, but don't have a current insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. Initials _____

2. **Copayments, Coinsurance and Deductibles**. All copayments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments, coinsurance and deductible balances from patients is considered fraud and could result in the termination of our contract with your insurance carrier. You will be asked to reschedule your appointment if you are not prepared to pay these amounts at time of service. Initials _____

3. **Insurance Status**. We provide medical care for all patients regardless of insurance status. Patients who do not have health insurance coverage (self pay) are required to pay for charges at the time of service. Our rates for self pay patients are reduced approximately 20% from the usual and customary charge made to insurance carriers. A copy of these charges is available at the front desk. Initials _____

Determining patient out-of-pocket costs from each visit is difficult due to the number of insurance plans and the variety of benefits offered by each plan. If we are contracted with your plan, we will bill them and wait for them to process your claim. Once we receive an explanation of benefits from your insurance carrier, any remaining patient balance will be due on that date.

4. Historically, we have mailed monthly patient statements out by USPS. Due to the increase in cost and poor patient response to mailed statements**, we are asking every patient to provide us with a credit card to be kept securely on file in our office**. Your card will not be charged until the Explanation of Benefits returns from your insurance carrier. The only amount charged will be the "patient responsibility" portion as defined by your insurance carrier. We will contact you before charging amounts over $200. Your credit card information will be securely encrypted in our practice management software (the same as your personal health information). If you do not have a credit card, we can also securely store your bank checking account and routing number.
   Initials _____

5. **Non-covered services**. Please be aware that some or all of the services you receive may be considered "non-covered" by your insurance carrier (including Medicare). You are responsible to pay any non-covered charges in full. Initials _____

6. **Claims submission**. In order to submit your claim to your insurance carrier, we must have your written authorization to do so. By signing this agreement below, you are providing that authorization.
   Initials _____

7. **Non-payment**. Any account balance which remains open at 90 days will result in termination of medical care provided by this office. Initials _____

8. **Missed Appointments (No-Show).** We charge $45 for missed appointments and appointments that are not canceled 24 hours prior to the appointment time. Initials _____

I have read and understand the payment policy as outlined above and agree to abide by its guidelines:

_____ Date _____

Patient Signature