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Acacia
FAMILY MEDICAL GROUP

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FINANCIAL POLICY

This is an agreement between Acacia Family Medical Group, as creditor, and Patient/Debtor named on this form.

In this agreement the words ñyou,ò ñyour,ò and ñyours,ò mean the Patient/Debtor. The word ñaccountò means the account that has been established in your name to which charges are made and payments credited. The words ñwe,ò ñus,ò and ñourò refer to Acacia Family Medical Group.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, and payments or credits applied to your account during the month.

Payments: Unless other arrangements are made and approved by us in writing, the balance on your statement is issued, and is past due if not paid by the end of the month. For your convenience we allow credit cards to be kept on file for any accrued balances. When a balance has accrued we will automatically charge your credit card instead of sending a monthly statement.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. There is a $25 fee for co-pays not paid at time of service. Therefore, if the co-pay is not paid at time of service, we will bill you for the co-pay plus an additional fee of $25.

Payment if you have no insurance:
Payment is due in full at time of service. You choose to pay by __cash, __check, or __credit card on the day that treatment is rendered. Payments made for services of patients without insurance will be given a discount for paying in full at the time of service. The discount would no longer be valid for partial payments when services are rendered.

Payment if you have insurance:
Payment of your co-pay/deductible and any out of pocket portions are due in full at the time services are rendered.

Returned checks: There is a fee of $25 for any checks returned by the bank. Once there has been a returned check on an account the account can only be paid by cash or credit card.

Missed Appointment Fee: Each time you do not show up on time for an appointment, or cancel with less than 24 hours notice, a $25 fee will be charged to your account.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred.

Collection Accounts: Once your account has been turned over to a collection agency, the balance incurred with our office must be paid in full before further services are rendered. If the balance cannot be paid in full, any future visits would then be paid in full at the time services are rendered until the previous balance is paid. If accounts are repeatedly in or near collections, we may not be able to continue to see you in our office.

Waiver of confidentiality: You understand if this account is turned over to a collection agency the fact that you received treatment at our office may become a matter of public record.

Bankruptcy: If you have filed bankruptcy we will adjust off any past balance as of the date the bankruptcy was filed. After a bankruptcy has been filed, if you decide to continue your care with our office, you would then be responsible for paying for all services when rendered.

Third Party Billing: Our office no longer accepts any new third party billing. This includes workers compensation and motor vehicle accidents. You would be responsible for paying at the time services are rendered. You would be responsible for the third party billing.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained here and the agreement will be in full force and effect.

Patientôs Name:_____
Responsible Party
(if not the patient):_____

Signature_____ Date: _____

Co-Signature:_____ Date: _____

Credit Card Type _____ Credit Card # _____

Expiration Date _____ Signature of Authorized user_____

Approved: _____ Date: _____