Patient Financial Agreement

Thank you for choosing our office as your primary care provider. It is our mission to provide quality, affordable health care to each patient. We have updated our financial policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full 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.
2. **Copayments and Deductibles.** All copayments and deductibles are to be paid at the time of service. This arrangement is part of your contract with your insurance company. If you have a high deductible insurance plan, you will be required to pay $50 toward your deductible at the time of service and we will bill you for any remaining balance after your insurance has processed the bill.
3. **Forms.** There is a $15 fee for completing Family and Medical Leave Act (FMLA), sick leave, disability and similar forms.
4. **Transfer of Medical Records.** As a courtesy, we will release a copy of your medical records to one new provider at no charge, on request. Any subsequent release of records will be charged to you at a rate of $0.75 per page.
5. **Registration.** All patients must complete our patient information forms so we can maintain accurate information for proper billing. We must obtain a copy of your photo ID and 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 you fail to notify us in a timely manner, you may be responsible for the balance of a claim. Most insurance companies have time filing restrictions; if a claim is not received within 30 days from the date of service, it can be rendered ineligible for payment and you will be responsible for the balance that remains.
6. **Claims.** We will submit your claims and assist you in any way we reasonably can to help you get your claims paid. Your insurance company may need you to submit certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays or not. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

7. **Uninsured Patients.** We offer a $75 flat fee per routine visit, payable at the time of service, for patients who do not have insurance. The flat fee for physicals is $120. Charges for any labs, treatments, X-rays or other tests are your responsibility. A sliding fee scale may be available for low income patients.
8. **Nonpayment.** If your account is over 90 days past due, you will be notified that you have 30 days to pay your balance in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, you may be discharged from this practice. If this occurs, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our providers will be able to treat you only on an emergency basis.
9. **Missed Appointments.** There will be a $25 charge for missed appointments not canceled within a reasonable amount of time. You will need to pay this charge before we can see you for another visit. These charges will be your responsibility and will be billed directly to you. Any patient who misses three appointments without calling to cancel ahead of time may be dismissed from the practice. Please help us to serve you better by keeping your scheduled appointments, or by calling ahead to cancel if you are unable to keep your appointment.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the financial policy of Renato Y Mandanas MD and agree to abide by its guidelines.

Print name:_____ Date:_____

Signature:_____

Relationship (if not patient):_____