VIDA FAMILY PRACTICE, PC. Payment Policy

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 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.

2. Co-payments and deductibles. All co-payments 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 co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Noncovered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply 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 or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in **[45 days]**, the balance will automatically be billed to you.

7. Nonpayment. If your account is over **[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 remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, 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 physician will only be able to treat you on an emergency basis.

8. Minor Patients. Written or verbal parental consent is required by law, if a minor is not accompanied by a parent. For families with dual insurance coverage, a birthday law applies. The birthday (birth month) of the parent that falls first is the year becomes primary

9. Missed Appointments: Due to our efforts to accommodate all patients when they need to be seen, we ask that if you are not able to keep your scheduled appointment, that you cancel no later than 24 hours in advance. We understand that although circumstances at times may prevent your doing this, after a second missed appointment we may add a $10.00 missed appointment charge to your account.

10. Other Fees. In the event that you need copies of your medical records transferred to another primary care physician a copy fee will be charged. Third party physical exams that requires additional forms to be completed by physicians or staff may be subject to a **$50.00 - $100.00 forms** fee. Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

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

Print Name of patient or responsible party	**Relationship**
Signature of patient or responsible party	**Date**