Patient Financial Agreement

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. Upon arrival, please sign in at our front desk and present your current insurance card and photo ID. You will be asked to sign and date the file copy of the card. This is your verification of the correct insurance and consent to them on your behalf. IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.
2. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
3. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.
4. If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.
5. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
6. Co-payments are due at time of service.
7. Patient balances are billed immediately on receipt of your insurance plan's explanations of benefits. Your remittance is due within 20 business days of your receipt of your bill.
8. Any balance over 90 days will be forwarded to our collections department and you will be charged an additional fee, which is 30% of the balance.
9. A $30 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
10. We charge a standard fee based on State of Michigan law to copy or transfer medical records. Details are available upon request.
11. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.

I have read and understand this Patient Financial Agreement and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s):_____

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Signature of Guarantor **Date**