

FINANCIAL POLICY

Legal Name (First, Middle, Last): _____ Date of Birth: _____

Thank you for choosing Horizon Family Medicine, PA for your family's medical care. We are committed to providing you with quality health care. We appreciate your commitment to adhere to this agreement.

- **INSURANCE** – Your medical insurance is a contract between you and your insurance company. Horizon Family Medicine is not a party to that contract. We will file insurance claims on your behalf, as a courtesy. In order for your claims to be processed timely and accurately **you must present a current insurance card and state issued photo ID at each visit**. If you arrive without your card, you will be responsible for all charges until the billing office has received complete, current and accurate insurance information. Horizon Family Medicine policy is to have **Social Security numbers on all patients** to file insurance claims – this helps protect the patient and Horizon Family Medicine from insurance fraud. All information provided to us is part of your confidential health record and is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
 - **Claim Submission** – If your insurance company requires you to supply information to them for processing of a claim you must comply with their request in a timely manner. **If your insurance company has not processed a claim on your behalf within 90 days of submission due to information that you have not provided, the balance will be transferred to your responsibility.** If a payment is received for that claim, you will be reimbursed by Horizon Family Medicine, PA within 15 business days.
 - **Medicare** – Medicare deductibles & co-insurances are expected at the time of service. As a participating provider with Medicare, we will file your claim to Medicare and if applicable, to your secondary insurance carrier. Please notify the front desk staff if you have recently changed Medicare plans. Third-party claims are the responsibility of the patient.
 - **Non-Contracted Insurance Plans** – Payment is required at time of service.
- **CO-PAYMENTS/DEDUCTIBLES/PAYMENTS** – **Payment is required at the time of service.** We currently accept Cash, Personal Checks, Visa, MasterCard, and Discover. If you have a financial hardship or if you are unable to pay your bill in its entirety, please contact our billing office **PRIOR** to your appointment to discuss payment arrangements. **There will be a \$35.00 service charge for all returned checks.**
 - **Self-Pay** – Uninsured patients are classified as Self-Pay. We can provide an estimate of our fees prior to services in the office. This is only an estimate actual charges may be higher or lower. Self-Pay patients may be given a **30% "Prompt Pay" savings** when their balance is paid at the time of service. You may also contact the Billing Office for payment arrangements.
- **MINORS** – **Parents and guardians are responsible for payments for their dependants at the time of service.** Patients between the ages of 16 and 18 can be seen without a parent or guardian present as long as parent or guardian is reachable by phone.
- **MISSED APPOINTMENTS** – Unless cancelled at least 24 hours in advance, a charge of **\$25 for missed appointments** may be applied. This fee is NOT covered by your insurance plan and is your responsibility.

OFFICE POLICY

- **LATE** – If you arrive more than 15 minutes late for your appointment you will be asked to reschedule.
- **PRESCRIPTION REFILLS** – Call your pharmacy and ask them to **fax a refill request to our office**. DO NOT wait until you are out of your medicine. Refill requests take 24-48 business hours.
- **FORMS** – Forms requiring medical review and physician signature – including school, day care, and camp physicals, prior authorizations, FMLA, disability or other paperwork –will be completed within 7-10 business days with a fee of \$15 due upon receipt. Please make sure to allow plenty of time for completion. Emergencies will be handled on a case by case basis.
- **PATIENT CONFIDENTIALITY** – In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a copy of the Horizon Family Medicine Notice of Privacy Practices is available to all patients in the office or online at www.HorizonFamilyMed.com.

READ & SIGN BELOW

I have read, understand and agree to the above Financial & Office Policy. I authorize Horizon Family Medicine to furnish medical information regarding my examinations and treatments to my insurance carriers, and assign all benefits payable to Horizon Family Medicine to be used towards the payment of my account.

Signature of Patient (or Legal Guardian)

Date