

Thank you for choosing Country Clinic as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to treatment at our facility. **You must present a current insurance card at each visit. If you or your children do not present a current insurance card, you will be responsible for payment at the time of your visit.**

Co-Payments, Deductibles, and Fees All co-payments, insurance deductibles, and fees for services not covered by your insurance policy **are due at the time service is rendered.** We accept cash, check or credit cards (VISA, MasterCard, Discover).

Insurance

It is your responsibility to:

- *Ensure our providers actively participate with your insurance carrier.
- *Know your benefit coverage, as well as your dependants prior to receiving service.
- *Ensure that all pre-approval requirements are met to avoid denials or out-of-network benefits.

We will accept assignment of insurance benefits for those plans we contract with. However, we do require co-payments and deductibles be paid at time of service, and the balance is your responsibility. Your insurance policy is a contract between you and your insurance company, and we are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 45 days, we may bill the balance to you. Your responsibility pertains to:

- *Denied and Non-covered services
- *Services deemed not medically necessary by your insurance company
- *Co-payments, deductibles, co-insurance
- *Pending claims due to lack of patient and/or guarantor information
- *Non-insurance and/or out-of-network benefits

Self-Pay/Uninsured Patients

A \$70 deposit will be required from all uninsured (self-pay) patients. This is to be paid before being seen.

Patients

Adult Patients are responsible for full payment at time of service. For Minors, the adult (parents or guardians of the minor) is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, Master Card, Discover, or payment by cash or check at time of service has been verified.

Missed Appointments/Charges

Unless canceled at least 24 hours in advance, we reserve the right to charge for missed appointments at the rate of **\$25** per missed appointment. If the appointment is an extended visit appointment (such as a physical which requires two appointment slots) then the rate is **\$50**. These fees are not covered by your insurance plan and are your responsibility. Please help us serve you better by keeping scheduled appointments.

There is a **\$20** charge assessed for all checks returned by your bank for non-sufficient funds.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy. I authorize the release of medical information necessary to process any claim. I authorize payment of benefits to Country Clinic, as agreed upon at the time of treatment.

X _____
Signature of Patient or Responsible Party Date