Derby Family MedCenter
1101 N. Rock Road
Derby, Kansas 67037

PATIENT FINANCIAL POLICY & INFORMED CONSENT
Appointments (316) 788-6369 Business Office (316) 789-1149

WELCOME
We are committed to providing you with the best possible care and we are pleased to discuss fees with you at anytime. *Your clear understanding of our Patient Financial Policy is important to our professional relationship.* Please ask if you have any question about our fees, our policies or your responsibilities. Carefully review the following information and return this form to us with your signature and today's date.

All patients must complete our *Patient Information Sheet* before seeing the doctor. It is your responsibility to notify our office of any patient information changes (i.e., address, name change, insurance, phone numbers, etc.)

INSURANCE
We will file your primary and secondary insurance claims as a courtesy to the patient by the current copy of your insurance cards on file. We will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to deductibles, co-payments non-covered chares, or "usual and customary" charges. Your insurance is between the patient, subscriber's employer, and insurance carrier. We will supply any factual information as necessary. **You are responsible for the timely payment of your account.** If there is no insurance responsibility, payment is due at the time services are rendered.

REFERRALS:
If a referral form is required for your insurance carrier, it is the patient's responsibility to obtain this form from their primary care physician prior to any appointments. Failure to obtain this form may result in a reduction of benefits by your insurance carrier. The account responsible party will be responsible for any charges incurred by the patient that is denied by the insurance due to the lack of insurance authorization.

CO-PAYMENTS:
Co-payment is due at the time you check in at the front desk **PRIOR** to being seen by the doctor.

UNPAID BALANCES:
We ask that payment in full be made at the time of service. If your insurance company has not paid the full balance, you will be sent a statement notifying you of the amount due, due upon receipt. **Any balances that are patient responsibility are due and payable in full.** *We accept cash, checks, money orders, or any of the following credit cards for payment: Visa, MasterCard, Discover or American Express.* Any overdue balances may be considered for collections and services terminated. To request an itemized copy of your current year's charges, you may be required to send a written request along with a $15.00 payment to our business office.

LATE FEE
You will **not** be assessed a **LATE FEE** on services if the Patient Balance shown on your current statement is paid in full within 56 days of the initial statement date. The **LATE FEE** will be a flat rate of $5.00 a statement after the 2nd consecutive patient responsibility statement.

COLLECTION COSTS AND ATTORNEY FEES:
In the event Family MedCenters. PA must incur collection costs or attorney fees in connection with your account, as permitted by applicable law, you agree to pay the reasonable costs of collection, including, but not limited to, court costs, attorney fees and collection agency fees.

RETURNED CHECKS:
The fee for a returned check is **$30.00** payable by cash, credit card, or money order. This will be applied to your account in addition to the insufficient fund amount. You may be placed on a "Cash Only" basis following any returned check.

MINORS:
The parent(s) or guardian(s) are responsible for full payment and will receive the billing statements. *Your signature is our release to treat an unaccompanied minor.*

PERSONAL ITEMS:
Please keep your personal items with you during office visit(s). Personal items are the responsibility of the patient.

MISSED APPOINTMENTS:
You may be charged for any missed appointment or late cancellation without a 24-hour prior notice.

I fully understand and agree to the above mentioned office policies of Family MedCenters, PA.

_____
PATIENT NAME (Please Print)

_____ _____
PATIENT/RESPONSIBLE PARTY SIGNATURE DATE

We appreciate the opportunity to provide our services for your medical needs. Your assistance and cooperation will be most appreciated. Should you have any questions or concerns, please contact a business office representative at (316)789-1149