Blairsville Internal Medicine

Patient _____ DOB _____ Chart _____

Financial Policies

Our healthcare providers, employees and agents strive to provide you with the highest quality medical care. The bills for charges resulting from professional services provided by the practices named below are the responsibility of the patient or his/her guarantor.

If you have medical insurance, your insurance is a contract between you and the insurance company. We are members of most major insurance networks and will file insurance claims for you if you have made an assignment of benefits to us. Not all services are a covered benefit in all contracts. Any charges that are allowed by your insurance company but are denied or not paid by them are your responsibility. We are legally required to collect co-payments on the day the services are provided. If a statement is sent, a $15.00 fee will be added.

If you do not have insurance, payment for services, billed according to our current fee schedule, is due at the time services are rendered. ***If you wish to establish a time payment plan, you must arrange it prior to seeing the doctor.*** Regular monthly payments are required and are due by the 15th day of each month.

A $30.00 fee will be charged for returned checks and you will be required to pay by cash or credit/debit card in the future. Past due accounts will be charged interest at the legal rate.

If Prior Authorization of prescriptions is required by your insurance or Pharmacy Benefit Manager, a $20.00 fee will be billed to your account.

Charges will be applied for missed appointments and appointments cancelled without 24 hours advance notice. A $25.00 fee will be charged for each missed or un-cancelled office appointment. Any patient that misses or fails to cancel three (3) scheduled office appointments may be given a 30-day notice to find another healthcare provider and dismissed from this practice. Failure to keep the Initial Visit will result in a $50.00 charge. If you are scheduled with one of our providers for a Hospital procedure, like a colonoscopy, and miss the appointment or fail to cancel with this office 24 hours in advance, you will be charged a $50.00 Missed Appointment Fee. For missed or un-canceled scans scheduled in our office, the fee will be $100.00 or our cost, whichever is greater.

We want you to receive the medical care you need. If you are having trouble paying your bill, please call our office. We may be able to arrange a payment plan or provide information for community help. If your account goes 90 days without payment, it may be referred to a collection agency and you will be discharged from the practices. Should your account be referred to a collection agency, collection fees, late charges and/or attorney charges may be added to your balance. Patients discharged from the practice are not accepted back.

1. FINANCIAL AGREEMENT: I acknowledge and agree that I am responsible for all charges for services provided to me which are not covered by my insurance plan(s) or for which I am responsible under my plan(s). To the extent no coverage exists under my plan, or I have no insurance coverage, I acknowledge that I am responsible for all charges for services provided and agree to pay those charges.

2. ASSIGNMENT OF BENEFITS AND PAYMENT REQUEST: I assign to the Practices named below all of my rights and benefits that I have in any medical insurance plan, health benefit plan, indemnity plan, trust, fund or other source of payment for healthcare services in connection with medical services provided by the Practices, employees and agents. I understand that this document is a direct assignment of my rights and benefits under my plan. I instruct my insurance company to pay the Practices directly for the professional or medical expense benefits payable to me

3. AUTHORIZATION FOR RELEASE OF INFORMATION AND CLAIM AUTHORIZATION: I authorize Provider and/or its agents to release any medical or other information about me in its possession to my insurance plan, the Social Security Administration, any state agency, or their intermediaries or fiscal agents required or requested in connection with any claim for services rendered to me by the providers at the Practices named below.

A photocopy of this Assignment shall be considered as effective and valid as the original.

_____ _____

SIGNATURE of Patient or Responsible Party (Guarantor) DATE

_____ DOB _____ SSN _____

Printed Name of Responsible Party (Guarantor)

Address _____ Phone _____