FINANCIAL POLICY

Clayton Medical Associates, P.A. believes that part of good health care practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1. PAYMENT is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, balances on account, or non-covered charges from your insurance company.

If you do not carry insurance, you are considered *self-pay*. Payment in full is expected at the time of you visit. Since self-pay charges can vary, our front office staff will collect $100 at check in and any additional fees, depending on the services provided, will be collected at check out. All MVA related visits are treated as *self-pay* (see above policy).

2. INSURANCE We are participating providers with several insurance plans. We will file all of these insurance claims. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment for your insurer, we will refund any overpayment to you.

If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with you insurer's member benefits department about services and physicians before your appointment.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge.

3. RETURNED CHECKS will incur a $25.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the returned check plus the $25 service charge to pay the balance prior to receiving services from our staff or the physician.

4. MEDICAL RECORDS: We require pre-payment for copying medical records and a signed medical records release form. Copying fees for Medical Records is seventy-five cents ($0.75) per page for the first twenty-five (25) pages, fifty cents ($0.50) per page for pages 26 - 100, and twenty-five cents ($0.25) for each page in excess of 100 pages.

5. CANCELLATIONS OR MISSED APPOINTMENTS: If you do not cancel your appointment at least 24 hours before, or if you no-show, we may assess you a $50 or $100 missed appointment fee. As a courtesy, our office will give you a reminder call two days prior to your scheduled appointment date. However, you are responsible for cancelling or rescheduling appointments and for notifying our office with any changes in your contact information.

6. RELEASE OF INFORMATION: I hereby authorize and direct Clayton Medical Associates, P. A. to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

7. COLLECTION FEES: I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

8. DIVORCED PARENTS of PATIENTS: By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____

Signature of Patient
(or Guarantor, if applicable)

Date

_____

Please Print the Name of the Patient