Patient Financial Policy

We are dedicated to providing the best possible care and service to you. Your complete understanding of your financial responsibilities is an essential element of your care and treatment. Please read carefully the financial policies as described below.

PAYMENT OF SERVICES: Payment for services rendered is ultimately the patient's responsibility. Your insurance is a contract between you and your insurance company. It is YOUR responsibility to provide us with correct information about your insurance plan. If your plan requires authorization it is your responsibility to provide this failure to provide this will warrant you responsible for any costs incurred. If you cannot provide a current medical insurance card, full payment must be made at the time of service. For your convenience we accept cash, personal checks, most major credit and debit cards.

CO-PAYMENT OF SERVICES: Your insurance company requires you to pay your co-payment at the time of service. Failure to pay is a violation of your contract with your insurance company. Please do not ask us to bill you for your co-pay. Procedures (ex: treatments, injections, etc.) are considered "procedures" and the fees for theses services may require separate deductibles or copays as determined by your insurance policy. Any co-payments are required to be paid at the time of service or upon notification. We cannot waive co-payments, deductibles, co-insurance responsibilities or non-covered service amounts that are determined to be the patient's responsibility per contractual obligation. We make every effort to follow the guidelines set by the various insurance companies. If you do not inform us of any special requirements your plan has and we subsequently perform a service that is denied, we have no choice except to bill you directly for those charges. If payment is not received from your insurance company within 45 days from the date of service, you will be billed for the services rendered. You will also be billed for any services not covered by your insurance company. Non- emergency treatment will be denied unless non-covered charges and co-payments have been paid and insurance billing is approved under the insured's policy.

COLLECTIONS POLICY: If you have an outstanding balance, we will mail you a statement monthly. A prompt response is expected. Failure to pay your portion of insurance allowable is a violation of your insurance contract and could result in insurance cancellation. If you default on your promised payment, our policy is to refer to a collection agency. The balance will accrue a monthly interest fee and an additional fee for the expense related to collections this fee is $30.00. Checks returned to our office for non-sufficient funds (NSF) will incur a $40.00 service charge.

CANCELLATION/MISSED APPOINTMENTS: Patients are seen by appointment. If you cannot keep your appointment it is your responsibility to call at least 24 hours in advance. Appointments that are not cancelled 24 hours in advance will be charged $25.00. Patients who miss their appointments and fail to call will be charged $25.00.

LABORATORY FEES: We try to utilize contracted laboratories for all of our patients, however there are times that we send specimens out and the laboratory will send it on to pathology or another provider, in the event this occurs we can not be responsible for any charges that might be incurred.

MISCELLANEOUS POLICIES: Unaccompanied minors must have a signed consent by a parent or guardian and be sent with a method of payment for their co-pay. The parent or guardian who signs the consent and authorization form is responsible for any balance on the account. Should you request copies of your medical records, there is a fee charged as allowed by current Florida statues. There is also a cost associated with your request for physician narrative reports and or letters not related to insurance claims. These fees would be based on the complexity and amount of time involved.

I have read and understand the terms of this financial policy. I understand and agree that such terms may be amended from time to time by practice. I agree and assign insurance Benefits to **Trinity Doctors Group** authorize the release of medical information to any consultants/ medical facilities if needed and as necessary to process insurance claims, insurance applications and prescriptions.

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Signature of patient or Responsible party Date