EDINGER
MEDICAL GROUP

Patient Financial Policy and Agreement:

Edinger Medical Group (EMG) is committed to serving your healthcare needs. Please understand payment of your bill is considered part of your healthcare relationship with our medical group and physicians. The following is a statement of EMG's Financial Policy. EMG requires you to read and agree to the financial policy prior to receiving treatment.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS

INSURANCE BILLING

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. It is your responsibility to know your benefits and how they will apply to the treatment you receive. If your insurance company has not paid your account in full within 60 days, the balance will be transferred to you and/or the guarantor listed on the Patient information form. All patients are responsible for their co-payment, co-insurance, unmet deductible and cost of non-covered services at time of visit.

HMO PLANS (with which we are contracted)

All co-pays must be satisfied at every visit. Due to contractual and uniform compliance issues with your insurance company, there are no exceptions to the policy of collecting co-pays at every visit.

PPO PLANS (with which we are contracted)

We will bill your insurance company as a courtesy. Any remaining balances due after contract adjustments and health plan payments are your responsibility. You will receive a statement for this remaining financial responsibility. All patient balances are due within thirty days of our statement date to avoid additional billing charges. For patients with PPO plans that we are not contracted, payment for all office services is due at time of visit.

CASH PATIENTS

All services must be paid in full at time of treatment. Our office can provide you with an estimate of the cost of treatment prior to your visit.

PAST DUE ACCOUNT BALANCES

Patients with an outstanding balance deemed overdue must make arrangements for payment prior to scheduling future appointments. Should your account become seriously overdue, it will affect scheduling of new appointments and refill of medications in a timely fashion.

SUSPENDED ACCOUNTS AND TERMINATION OF CARE:

In the event outstanding balances are not paid within 90 days, your patient status will be suspended. Once suspended, your doctor-patient relationship with the medical group will be terminated, and you will need to receive care and necessary medication refills

(OVER)

elsewhere. Should you have questions or concerns regarding on-going care or seeking alternate care after suspension, please contact your physician.

REPORTING OF DELINQUENT ACCOUNTS TO CREDIT AGENCIES:
If a patient account balance becomes delinquent and the patient account is suspended, that delinquent balance will be reported to national credit agencies. This may affect your current and long term credit status adversely. These delinquent balances will remain in affect with these credit bureaus indefinitely in the future until your overdue balance is paid.

BILLING FEE
For all account balances that are not paid within 28 days, a $10.00 billing fee will be assessed each time a subsequent billing statement must be generated. This billing fee will be added to your outstanding account balance.

DIVORCED / SEPARATED PARENTS
EMG does not get involved in custodial, separation or financial disputes involving or relating to divorced/separated parents for a minor child(ren) to whom we provide service. The parent who signs the financial policy and registration form of the minor child(ren) will be the responsible party for payment of services rendered.

PATIENT REFUNDS
The following criteria must be met prior to issuing a patient refund: no outstanding insurance claims on the family's account(s), and no outstanding patient balances on the family's accounts.

RETURNED CHECKS
A $25.00 fee will be charged for any returned checks.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my EMG account for any professional services rendered. I have read the above EMG Patient Financial Policy, agree to abide by it, and have provided EMG with true and correct insurance information. I will notify EMG of any change in my health insurance coverage.

_____
Print Patient's Name

_____ _____
Print Account Guarantor's Name (if different from above) | Relationship to Patient

_____ _____
Patient / Guarantor's Signature | Today's Date

☐ Please check this box if you would like to receive a copy of this document.