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 providers. The following is a statement of EMG's Financial Policy. EMG requires you to read, initial, 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 health 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 the time of the visit.

Depending on whether you are an HMO, PPO or CASH patient, you are only required to initial next to the statement that applies to you:

CONTRACTED HMO PLANS *only initial if you are an HMO patient

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.
Initial Here: _____

CONTRACTED PPO PLANS *only initial if you are a PPO patient

We bill your insurance company as a courtesy. **All co-pays, co-insurance, unmet deductible, and cost of non-covered services will be collected at the time of the visit**. 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 30 days of our statement date.
Initial Here: _____

CASH PATIENTS *only initial if you are a CASH patient

For cash patients**. All services must be paid in full at the time of the visit/treatment.** Our offices will provide you with an estimate of the cost of treatment before the visit.
Initial Here: _____

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OUT OF NETWORK PLANS

For patients with plans that we are Out of Network**. All services must be paid in full at the time of the visit/treatment.** Our offices will provide you with an estimate of the cost of treatment before the visit.

PAST DUE ACCOUNT BALANCES

Patients with an outstanding balance deemed past due (90 days) must plan for payment prior to scheduling any future appointments. **Should your account become seriously past due, it will affect scheduling of any new appointments and refill of medications in a timely manner.**

SUSPENDED ACCOUNTS AND TERMINATION OF CARE

In the event outstanding balances are not paid within 120 days, your patient status will be suspended. Once suspended, your provider/patient relationship with the medical group will be terminated, and you will need to receive care and necessary medication refills elsewhere.

REPORTING OF DELIQUENT 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 credit bureaus indefinitely in the future until your overdue balance is paid.

PATIENT REFUND

The following criteria must be met prior to issuing a patient refund:
No outstanding insurance claims on the patient account.
No outstanding patient balance on the patient account.

By initialing here, you have read and understand the statements above. Initials: _____

RETURNED CHECKS

A $25.00 fee will be charged for any returned check.

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 **Patient Signature**

_____ _____

Print Responsible Party Name (if different from Patient) **Date**

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