CHICKAHOMINY FAMILY PRACTICE, INC.

CHICKAHOMINY FAMILY PHYSICIANS-QUINTON
1850 POCAHONTAS TRAIL
QUINTON, VA 23141

CHICKAHOMINY FAMILY PHYSICIANS-PROVIDENCE FORGE
9010 POCAHONTAS TRAIL
PROVIDENCE FORGE, VA 23140

CHICKAHOMINY FAMILY PHYSICIANS-MAIDSTONE
11847 ASPENGRAF LANE SUTIE B
NEW KENT, VIA 23124

CHICKAHOMINY FAMILY PHYSICIANS-NEW MARKET
2660 NEW MARKET ROAD
RICHMOND, VA 23231

FINANCIAL POLICY

_____ **PATIENT WITH INSURANCE**: YOU ARE RESPONSIBLE FOR DEDUCTIBLES CO-PAYS, NON-COVERED SERVICES AND COINSURANCE. CO-PAYMENTS AND COINSURANCE ARE DUE AT THE TIME SERVICES ARE RENDERED. THE REMAINING BALANCE IS DUE WITHIN ONE (1) MONTH OF NOTICE FROM THE INSURANCE COMPANY. IF INCORRECT INSURANCE INFORMATION WAS PROVIDED AND /OR COULD NOT BE VERIFIED YOU WILL BE RESPONSIBLE FOR THE BALANCE. IF YOU OR YOUR INSURANCE CARRIER MAKES A PAYMENT EXCEEDING YOUR BALANCE, REIMBURSEMENT WILL BE REMITTED.

_____ **PATIENT WITH INSUFFICIENT PROOF OF INSURANCE COVERAGE**: A VALID COPY OF THE INSURANCE CARD **IS REQUIRED.** IF YOU DO NOT PRESENT YOUR INSURANCE CARD YOU WILL BE ASKED TO RESCHEDULE YOUR VISIT OR PAY THE BALANCE IN FULL AT THE TIME OF SERVICE. IF YOU PAY YOUR VISIT AND SUBSEQUENTLY PROVIDE YOUR INSURANCE CARD WE WILL FILE YOUR VISIT AND ANY RESULTING OVERPAYMENT WILL BE REFUNDED. **NOTE: IN ORDER TO FILE YOUR INSURANCE YOU MUST PRESENT THE INSURANCE CARD WITHIN YOUR CARRIERS SPECIFIED FILING PERIOD**.

_____ **PATIENT WITH NON PARTICIPATING INSURANCE**: IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE PLAN YOUR CLAIM WILL BE FILED ONE (1) TIME AS A COURTESY ONLY. IF THE INSURANCE CARRIER HAS NOT PAID THE CLAIM WITHIN 60 DAYS THE BALANCE WILL BE BILLED TO YOU AND IS DUE UPON RECEIPT.

_____ **PATIENT WITHOUT INSURANCE (PRIVATE PAY):** PAYMENT IS DUE AT THE TIME OF SERVICE. IF YOU CANNOT PAY THE BALANCE IN FULL YOU MUST MAKE ARRANGEMENTS WITH THE FINANCIAL COUNSELOR TO SET UP A PAYMENT PLAN.

_____ **PATIENT WITH WORKER'S COMPENSATION:** AS A WORKER'S COMPENSATION PATIENT YOU MAY BE COVERED BY INSURANCE. IF YOUR INJURY WAS REPORTED AT WORK AND VERIFIED WITH YOUR EMPLOYER. BE SURE TO INFORM OUR FRONT OFFICE PERSONNEL THAT YOUR INJURY RESULTED DURING EMPLOYMENT. **NOTE:** NEW MARKET MEDICAL CENTER DOES NOT TREAT WORKER'S COMPENSATION INJURIES.

_____ **PERSONAL INJURY (ACCIDENT):** IF YOU ARE A PERSONAL INJURY PATIENT OUR OFFICE WILL BILL YOUR MEDICAL INSURANCE POLICY **ONLY. WE DO NO FILE THIRD PARTY INSURANCE (FOR EXAMPLE: CAR INSURANCE POLICIES).** IF WE ARE UNABLE TO OBTAIN PAYMENT, CHARGES FOR THE SERVCES RENDERED, WILL BE YOUR RESPONSIBILITY. IF AN ATTORNEY IS INVOLVED AND ASKS YOU NOT TO SUBMIT THE INSURANCE CLAIMS, PAYMENT WILL BE DUE AT THE TIME SERVICES ARE RENDERED.

_____ **PATIENT WITH MEDICARE:** OUR OFFICE WILL SUBMIT YOUR MEDICARE CHARGES TO PALMETTO GBA, LLC. AND YOUR SECONDARY INSURANCE. YOU ARE RESPONSIBLE FOR DEDUCTIBLES, COPAYS AND ANY NON COVERED SERVICES.

_____**MISSED APPOINTMENTS:** IF YOU ARE UNABLE TO KEEP YOUR SCHEDULED APPOINTMENT AND FAIL TO CANCEL IT YOU WILL BE CHARGED A FEE OF $25. IF YOU FAIL TO CANCEL A **PHYSICAL** YOU WILL BE CHARGED A FEE OF $50. IF YOU MISS THREE APOINTMENTS AND YOU DID NOT CANCEL THEM IN ADVANCE YOU WILL BE ASKED TO SEEK MEDICAL CARE FROM ANOTHER PHYSICIAN/FACILITY OUTSIDE OF CHICKAHOMINY FAMILY PRACTICE, INC.

_____**RETURNED CHECKS:** THERE WILL BE A RETURNED CHECK FEE OF $35 ASSESSED FOR EACH RETURNED CHECK.

******YOU ARE RESPONSIBLE FOR PAYING ANY BALANCE THAT IS THIRTY (30) DAYS OR MORE PAST DUE BEFORE YOU MAY BE SEEN. IF YOU ARE UNABLE TO PAY YOUR BALANCE FEASIBLE PAYMENT ARRANGEMENTS MUST BE APPROVED THROUGH THE BILLING DEPARTMENT BEFORE ANY FUTURE APPOINTMENTS MAY BE SCHEDULED. ANY FEES INCURRED BY CHICKAHOMINY FAMILY PRACTICE IN AN ATTEMPT TO COLLECT OUTSTANDING DEBTS WILL BE ADDED TO YOUR ACCOUNT BALANCE. *******

ACCOUNT BALANCES THAT ARE OUTSTANDING PAST 90 DAYS MAY BE REFERRED TO A COLLECTION AGENCY.

I HAVE READ AND AGREE TO THE FINANCIAL POLICY STATED ABOVE THAT APPLIES TO ME.

_____ _____

PATIENT OR RESPONSIBLE PARTY SIGNATURE **DATE**

_____ _____

PERSON SIGNG ON BEHALF OF PATIENT (PRINT NAME) **REASON PATIENT CANNOT SIGN**

_____

RELATIONSHIP TO PATIENT **ADDRESS** **PHONE NUMBER**