

Peace Valley Internal Medicine, P.C.

PRACTICE POLICIES

Thank you for choosing Peace Valley Internal Medicine as your healthcare provider. We are committed to providing the best possible medical care to our patients in a most efficient and effective manner.

Listed below is our **Financial Policy**, which we ask you to read prior to your treatment by our providers.

1. It is your responsibility to have your insurance card on every visit, for us to confirm any changes.
Rebilling your insurance company because of incorrect insurance information \$10.00
2. All co-pays are expected at the time of service. We accept cash, checks, and credit cards for payment.
Non-payment of co-pay at time of service \$10.00
3. For Checks returned to us for insufficient funds \$35.00
4. Missed appointment without at least 24 hours' notice prior \$25.00
5. All bills are payable within 30 days of receipt. Bills not paid within 30 days \$10.00
6. Delinquent accounts may be referred to a collection agency \$25.00
7. Completion of forms not associated with an office visit \$10.00 - \$25.00
8. Copying chart for patients (based on # pages)..... up to \$35.00

Cancellations - In order to provide the best service to all our patients, we ask that you provide us with at least 24 hours' notice if you cannot keep your scheduled appointment. If you miss your appointment without notifying our office in advance, we reserve the right to charge for the missed appointment. This fee is not covered by insurance so it will be your responsibility. If you miss three scheduled appointments, you may be dismissed from our practice. You will be notified as such by our office and you will be asked to find another provider.

Referrals – 48 hours notice required for all HMO referrals except for emergencies.

Prescriptions – Please request medications at time of visit. We require **24 hours'** notice for all prescriptions called into the office.

Test reports – These may be picked up at the office free of charge. We will not fax/email reports to patients except for emergencies. Reports will be faxed to other health care providers, at the patient's request – free of charge.

Insurance – It is your responsibility to understand and comply with any predetermination of benefit or referral requirements with your particular insurance plan. Please be aware that some, and perhaps all, of the services provided by our practice may be a non-covered service or may not be medically necessary by your insurance company. You are responsible for payment of these services in full at the time of visit or as soon after the insurance determines what is or is not covered under your policy.

Assignment of Benefits: I Hereby Assign to Peace Valley Internal Medicine all benefits payable to me for my care and/or treatment.

For Medicare Patients: I certify the information I have provided in applying for payment under the Title XVIII of the Social Security Act is correct. I am aware that I may incur a coinsurance liability for services provided by Peace Valley Internal Medicine.

HIPAA: I acknowledge that Peace Valley Internal Medicine Notice of Privacy Practices has either been provided or made available to me.

I have read and understand Peace Valley Internal Medicine's Financial and Office Policy and agree to comply with the terms of the policy.

Signature of Patient / Legal Guardian

Date

Print Patient Name/ Legal Guardian

Date of Birth