Journey
Family Medicine

Office & Financial Policy

In the interest of a good health care practice, it is desirable to establish an office and financial policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health and we wish to spend our time and energy towards that end.

1. You will be asked to provide our office with your social security number and health insurance card (if applicable) unless your total charges are paid in cash at the time of service. Treatment may be postponed if the above are not furnished by the patient.

2. All accounts are due and payable at the time of your visit, unless arrangements have been made with the business office. These arrangements must be approved before treatment is rendered.

3. If patient is uninsured, there will be a 25% discount on office visits paid in full on the day of service. This does not pertain to immunizations, procedures or supplies. Previous account balances are not discounted.

4. Insurances will be billed by the clinic as a courtesy. It is the responsibility of the patient to verify that the clinic has their correct insurance information and to inform the clinic if there are any changes with their insurance provider. The clinic will not be responsible for rebilling insurance after 90 days from date of service. Remember, an insurance policy is a contract between the patient, the patient's employer, and the insurance carrier. Ultimately, the PATIENT is responsible for the timely payment of their account. Co-pays and deductibles are due at the time of service.

5. Although the clinic will attempt to text or email the patient before their scheduled appointment, this is only a friendly reminder and patients who schedule their appointment will be expected to keep their appointment whether or not they received a courtesy reminder by the clinic. The clinic will not reschedule any patients after three appointments have been missed. The clinic's time must be used as efficiently as possible to keep our expenses at a minimum and our fees within reasonable limits.

I have read this office and financial policy and understand that regardless of any insurance coverage I may have, I am responsible for payment on my account. Also, if it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment. This will ensure that our responsible patients will not be penalized to cover costs incurred by those who do not pay on time.

I hereby authorize the above doctor/doctors to provide such medical services including minor surgery, if necessary, either regular or emergency as may be determined to be in the best interest of those members of my immediate family, as listed above, who are minors. This authorization shall continue and be in full force and effect revoked in writing.

I have received a copy of Journey Family Medicine Notice of Privacy Practices.

Parent/Guardian/Responsible Party's Name: _____

Parent/Guardian/Responsible Party's Signature: _____

Date of Birth: _____

Today's Date: _____