Journey
Family Medicine

Office & Financial Policy

Welcome to Journey Family Medicine where we are partners on your healthcare journey!

1. Co-pays and deductibles are due at the time of service.

2. Your social security number and medical insurance card are required at the time of service, unless your total charges are paid in full, in cash at the time of service.

3. 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. 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.

4. A 25% discount is available if the clinic does not bill your insurance and you pay in full at the time of service. This does not apply to immunizations, supplies or account balances.

5. All accounts are due and payable at the time of your visit.

6. If you need to cancel or reschedule your appointment, please notify the office 24 hours in advance. The clinic may not reschedule any patients after three appointments have been missed without advance notification. (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.)

7. Our providers do not routinely prescribe most controlled medications such as opioids, benzodiazepines and some sleep medications for daily or long-term use. Our providers do not prescribe stimulant medications without a formal diagnosis from a licensed behavioral health provider.

I hereby authorize Journey Family Medicine to provide medical services including minor surgery, either regular or emergency as may be determined to be in my best interest, including minors listed below. This authorization shall continue and be in full force and effect until revoked in writing. I have read the Office & Financial Policy and understand that I am fully responsible for payment on my account. If it becomes necessary to refer to collections, any amount owed on this or subsequent visits, I the undersigned agree to pay for costs and expenses, including reasonable attorney fees.

I hereby authorize Journey Family Medicine to release information necessary to secure payment. I have received a copy of Journey Family Medicine Notice of Privacy Practices.

Patient Name: _____ Date of Birth: _____

Name of legally responsible person, if different than patient: _____

Relationship to Patient: _____

Signature of patient or legally responsible person: _____ Today's Date: _____