

Welcome to Longs Peak Family Practice. The information below is intended to answer some of the common questions about our financial and office policies. We welcome the opportunity to discuss any aspect of our policies with you, please feel free to ask our office staff, Business Manager or our Providers. We value you as a patient and strive to provide you with the highest quality of healthcare. Thank you for choosing Longs Peak Family Practice for your healthcare needs.

Financial Policy Statement

Co-Payments, Deductibles, and Previous Balances

All copays are due at the time of service and will be collected when you check in. If you are unable to pay your required copay on the day of service, a \$10.00 non-payment of copay fee will be charged to your account. We accept cash, checks, Visa and MasterCard as forms of payment.

If you have a high deductible with your insurance plan, and have not met the required amount set forth by your insurance company, you may be required to pay at least 1/2 of the charges you incur at the time of your visit. You will then be billed any amount due that is left after your insurance company processes your claim.

Previous balances are due upon receipt of any statement and/or will be collected at the next visit, which ever comes first. We do realize unforeseen circumstances sometimes arise and therefore, we are happy to set up a reasonable written payment plan with you. It is your responsibility to contact our office to set this up as soon as you receive your first statement in order to keep your account in good standing.

Initial: _____

Insurance Plans

If you have an insurance plan that we are a participating provider or have a contract with, we will submit your claims as per our agreement with your insurance company. Although we may be a participating provider with your insurance company, there are times when claims are denied by your insurance company. **It is extremely important that we have the correct insurance information at each and every visit. Failure to notify us of any insurance changes may result in a denial of your insurance claim and all monies owed will be your responsibility.**

If you do not have an insurance plan that we have a *contract* with, you will be responsible for FULL payment of all charges you have incurred at the time of your visit. You will be given copies of your charges at the end of your visit for you to submit to your insurance company for reimbursement.

Initial: _____

Collection Accounts

Accounts with outstanding balances over **90** days may be turned over to a Collection Agency of our choice. Once an account has been turned over, we will no longer be able to provide medical care to any family members that are under your account.

Initial: _____

Financial Policy, continued

Medicare

Medicare requires we bill claims to them on behalf of our patients and we are happy to do so, but unless you have a supplement or secondary insurance that we are participating in or have a contract with, we will not accept assignment, direct payment from Medicare.

Therefore, if we are billing only Medicare and not a secondary insurance for you, you will be required to pay at the time of visit and Medicare will send any payments directly to you.

Initial: _____

Minors / Full Time Students

Parent(s)/Guardian(s) are responsible for payment of all charges incurred by a minor or full time student that are not covered by the insurance company. We will not be responsible for billing or collecting from another party, i.e. divorced or separated spouses. We also will be unable to send bills directly to your child at their school of residence Please refer to Co-Payments, Deductibles and Previous Balances on first page.

Initial: _____

Returned Check Fees

There will be a \$20.00 returned check fee added to your outstanding balance when our bank returns your check to us, regardless of the reason. Your account status with us will then be cash or credit card as the only acceptable forms of payment. Any unpaid returned checks and fees will be turned over to a Collection Agency of our choice.

Initial: _____

I have read the Financial Policy Statement, and I understand and accept its provisions.

Signature of Patient or Responsible Party

Date

Printed Name of Patient or Responsible Party

LPFP Representative