Financial Policy

Thank you for choosing Fox Ridge Medical Associates. For us to be able to continue to provide you with a high level of care, it is important to have a thorough understanding of your financial responsibility. Please read this form carefully, as your acceptance of our financial policy is required before you see the provider.

You are responsible for any co-payments (due at the time of service), deductibles and non-covered services. While every effort is made to bill services under the codes most likely to be covered by insurance, different insurance policies have different rules, and the coverage changes over time.

It is your responsibility to understand your insurance coverage and benefits, and to let the provider know at the time of the visit whether certain labs or other tests are covered as "preventive" service (i.e. under diagnosis code Z00.00) Please be aware that if significant other health issues are addressed at the time of a "Wellness" visit, there may be an additional charge.

You are required to present a valid health insurance card, as we cannot bill your insurance without that information. Alternatively, if you choose to be a "self- pay" patient, you will be required to pay a $150.00 deposit at the time of the appointment, with adjustments applied after the bill is finalized.

Patients will be billed monthly, with the balance due within 30 days. Any balance not paid in full will incur a $15.00 rebilling fee each month, unless other arrangements have been made with our billing department. Failure to make the agreed-upon payments may result in your account being sent to a collection agency, at which time you may be terminated from services. Any checks returned for non-sufficient funds will incur a $25.00 charge.

Financial responsibility for minors is assumed by the parent or guardian.

We ask that is you should need to cancel your appointment, please give us at least 24-hour notice. Failure to show up for a scheduled appointment will result in a $50.00 no-show fee. Patients who repeatedly fail to keep appointments may be terminated from services.

Your signature below attests that you have read and understand this document, and that you agree to abide by the above financial policy.

Signature of Patient (or responsible party) _____ Date_____

Printed name of patient_____