Fox Ridge
Medical Associates

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. *All outstanding balances must be paid before services will be rendered.* 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. INITIAL _____

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 at the time of service, a 20% discount will apply to the visit charge. All workman's compensation and accident claims are considered cash pay and must be paid at the time of service. Fox Ridge does not bill these types of claims.
INITIAL _____

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, a billing portal is available. Billing portal access is available on the statement you receive. Patients terminated for non-payment of services will be required to pay account in full along with a 35% collection fee of that balance and $100 reinstatement to be provided services by Fox Ridge Medical Associates. Any checks returned for non-sufficient funds will incur a $25.00 charge. INITIAL _____

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. **Appointment reminders are not guaranteed and are a courtesy.**
INITIAL _____

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_____