Willow Creek Family Medicine

FINANCIAL POLICY

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services. This includes applicable coinsurance and copayments for participating insurance companies.

Willow Creek Family Medicine accepts cash, personal checks (in-state only), VISA, and MasterCard.

Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling appointments.

INSURANCE:

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier.

We are not in network with United Health Care.

Return Checks:

A $35.00 charge will be added to your account for any check returned by your bank for any reason.

Worker's Compensation

If your injury is due to an accident in your work place, please be sure to contact your employer and inform them of your injury. We will need to receive required information from your employer before we can process any of your medical claims. Denied claims will become your financial responsibility.

Auto Accident Injury

If your injury is due to an automobile accident, we request that you provide us with any information that will assist us in getting your medical claims paid. This information may include copy of the police report, copy of your auto insurance, medical insurance, names and information on other parties involved. Any unpaid services provided will be your responsibility.

DIVORCED PARENTS of PATIENTS

By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues

I have read and understand the **Willow Creek Family Medicine** Financial Policy. I agree to assign insurance benefits to **Willow Creek Family Medicine** Practice whenever necessary.

Patient Signature: _____Date: _____

I, the undersigned client/guardian, agree to pay for all services rendered and/or goods sold to me or my family immediately upon demand. I further agree that in the event of non-payment of any amounts due under this agreement I will pay interest thereon at the rate of 1.5% per month and pay all reasonable attorney fees and court costs that may be incurred. I agree that in the event this agreement is assigned to an agency for collection, I promise to pay an additional collection fee of 35% of the unpaid balance due.

Signature of Patient/Guardian: _____ Date:_____