We are committed to providing you with the best possible care, and we are pleased to discuss our professional fee with you at any time. Please ask us if you have any questions about our fees, financial policy, or what your financial responsibility might be.

All new patients will be asked to complete a Patient Information Sheet prior to being seen by the physician. We ask that you complete all information including your insurance information, even if we are not filing for your office visits. We also will need to make a copy of your insurance card and driver's license each time you come in to ensure that your financial information is current.

SELF PAY

I understand I am expected to pay for services in full at the time the services are rendered.

____
(Patients initials, if applicable)

APPOINTMENT CANCELLATION POLICY

I understand that I must give at least 24-hours notice if I need to cancel a scheduled appointment. I understand that if I do not give the required notice to cancel an appointment, **I may be charged $30 per occurrence.**

____
(Patient initials)

INSURANCE INFORMATION

If you are covered by any of the insurance plans for which we are a participating provider, we will be happy to file your claims. However, if we are not participating providers, it is your responsibility to provide our office with the correct billing information.

____
(Patient Initials)

I understand that I am directly responsible for any charges not covered by my insurance carrier. All co-payment, co-insurance, and/or deductibles are due at the time of my visit.

I understand that it is my responsibility to obtain proper referral authorization(s) as required by my insurance carrier. Rejection of any claim due to improper/ and or deductibles are due at the time of my visit.

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(Patient Initials)

UNACCOMPANIED MINORS

The parent (or guardians) will be responsible for full payment unless covered by a participating managed plan. Authorization to treat an unaccompanied minor must be on file.

The physicians and staff of Baptist Primary Care thank you for accepting our Financial Policy as indicated by your signature below. If you should have any questions or concerns, please feel free to ask.

____
Responsible Party Signature

____ ________________________________
Patient's Name (Please Print) Date

Methods of Payment
Cash, Check and Credit Cards are accepted.