

**Baptist Primary Care**  
**OUR FINANCIAL POLICY**

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

*\*All new patients will be asked to complete a Patient Information Form 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. This information may be needed in the future.*

*\*We also ask to make a copy of any type of pictured identification to remain a permanent part of your chart.*

**INSURANCE INFORMATION**

*If you are covered by Medicare, Champus or any of our managed plans, we will file your insurance claim. You are responsible for any co-pay, co-insurance, deductible, or non-covered services at the time of your visit. If we do not participate with your insurance company, you will be responsible for full payment at the time of your visit.*

*All self-pay patients are expected to pay for services in full at the time that services are rendered.*

*We will file with all insurance plans for our professional fees for any hospital admissions.*

*In the event your insurance company does not pay the full balance within 90 days, we will notify you so that you may contact your insurance carrier. Please remember that ultimately, payment responsibility rests with the patient.*

*Please advise the office personnel of any changes in your insurance or mailing address.*

*Payment arrangements can be arranged with the Office Manager prior to services being rendered.*

*Should it ever become necessary to use the services of a collection agency to collect your account, you would be responsible for any costs incurred for that purpose.*

*I hereby authorize Baptist Primary Care to bill my insurance company directly for these services. I understand I am financially responsible for charges not covered by my insurance company. I authorize any holder of medical or other information about me to release to the Social Security Administration or intermediaries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits either to myself or to the party who accepts assignment. I certify that the above information is currently correct.*

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PATIENT OR PARENT (GUARDIAN)

**WORKER'S COMPENSATION**

*Worker's Compensation patients will be seen only after the proper authorization and paperwork has been received.*

**UNACCOMPANIED MINORS**

*The parents (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.*

**COMPLETION OF FORMS**

*Baptist Primary Care reserves the right to charge a nominal fee for the completion of disability and/or Family Medical Leave forms.*

*There will be a \$30 charge for no show or cancellation without a 24 hour notice. Your insurance company will not cover this charge.*

*We thank you for understanding our financial policy. If you should have any questions or concerns, please feel free to ask. Please sign below to acknowledge your understanding of this policy.*

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Patient's Name (Please Print)

\_\_\_\_\_  
Date

**METHODS OF PAYMENT**

CASH, CHECK, VISA AND MASTERCARD are all accepted.