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Financial Policy

Thank you for choosing Sierra Nevada Family Medicine as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment. All patients **must complete** our information and insurance form before seeing the doctor.

COPAYMENTS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE.
WE ACCEPT CASH, CHECK, & VISA and MASTERCARD as methods of payment.

REGARDING INSURANCE

We may accept assignment of insurance benefits: however, we do require 100% of the co-payment and deductible to be paid at the time of service. The balance is your responsibility whether your insurance pays or not. ***We cannot bill your insurance company unless you give us correct information.*** Your insurance policy is a contract between you and your insurance company. We are not party to the contract. ***If your insurance company has not paid your account in full within 90 days, the balance will be the patient's responsibility.*** Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance plans. These non-covered charges are your **responsibility.** In the event that we are not participating providers in your plan, or your insurance plan changes, the patient is responsible for all incurred charges.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

ADULT PATIENTS

Adult patients are responsible for full payment of co-pay and deductibles at the time of service.

MINOR PATIENTS

The adult accompanying a minor (or guardian of the minor) is responsible for full payment or co-pays and deductibles at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard, or payment by cash or check at the time of service. A letter must accompany the minor from the parent or guardian for that specified date of service authorizing medical care. We do not accept letters authorizing extended dates of service.

MISSED APPOINTMENTS

Our office requires 24 hours notice if you are unable to keep a scheduled appointment. If we do not receive a 24 hour cancellation notice, our office will issue a letter expressing our concern for your failure to appear for the scheduled appointment. Due to our staff's inability to reschedule this time for another patient, someone needing medical care may have been needlessly turned away. In the event that you have missed two appointments, you will be charged a **$25 fee** and are subject to termination from the practice. Please help us serve you better by keeping your scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

Name (Please Print)	**Signature of Patient/Guardian**	**Date**

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