On + Care
FAMILY HEALTH NP, PLLC

AGREEMENT OF FINANCIAL RESPONSIBILITY

Thank you for choosing On Care Family Health as your health care provider. We are committed to providing quality care and service to all patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

1. Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider, and are the designated Primary Care Provider (PCP), if applicable.

2. It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.

3. We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.

4. If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s). Copayments are always due at the time of service. If you have a deductible plan, and your deductible has not been met, we will require a partial payment at the time of service in the amount of $50.

5. Proof of Insurance and photo ID are required for all patients. We will make a copy of your ID and insurance card(s) for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

6. Medicaid/Managed Medicaid plans**:** It is your responsibility to call your insurance company and notify them of your change in PCP before services are rendered. Failure to do so may result in having to re-schedule your visit.

7. **Cancelation/No Show Fees:** You are required to provide our office with a 24-hour notice if you need to cancel/ reschedule your appointment. You may do so by calling our office or leaving a message on our 24/7 voicemail. You may not cancel/reschedule your appointment via the patient portal. A "No-Call", "No-Show" or cancellation of same day appointments, without proper 24-hour notification, will be assessed with a **$25.00 fee** for follow-up and sick appointments and a **$50.00 fee** for Annual Exams. These fees are not billable to your insurance company and must be paid prior to rescheduling your appointment. If you are 15 minutes or more late for your appointment, the appointment will be cancelled and rescheduled. As a courtesy, we make reminder calls, send e-mails and text messages in advance of your appointment. Please note, if a reminder call or message is not received, the cancellation policy remains in effect. Repeated missed appointments may result in termination of the provider/patient relationship.

I have read the financial policy above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____

Signature of Patient /Responsible Party **Date**

_____ _____

Name of Patient/Responsible Party (please print) *Relationship to Patient*