VISTA FAMILY MEDICINE FINANCIAL RESPONSIBLITY STATEMENT

Thank you for choosing Vista Family Medicine to serve your medical needs. As part of this, we wish to establish our expectations of your financial responsibility as outlined below. Your medical insurance is a contract between you and your insurance company. It is important to be informed regarding your individual benefits. We do have an in-office billing staff that may assist you with understanding your policy.

Consent to Services:

Patient hereby requests registration at **Vista Family Medicine** and voluntarily consents to any facility services deemed necessary or advisable as determined by the attending physician or his or her assistants of **Vista Family Medicine** with appropriate clinical privileges. Patient acknowledges that no guarantees have been made as to the results of treatments or examination at **Vista Family Medicine.**

Consent to Release Information:

The undersigned hereby authorizes **Vista Family Medicine** to release to employer groups, insurance companies, government agencies or other third-party payors and their agents information concerning diagnoses and procedures performed, medical care, advice, treatment, supplies or other information that may be necessary for the purpose of determining eligibility and available benefits and obtaining payments on the patient's behalf for the health care services rendered to the patient. Patient (responsible person) acknowledges that he or she will be financially responsible for charges incurred for the patient's treatment if revocation or refusal to authorize the disclosure of the medical records results in a payment denial of the insurance claim.

Medicare Patients:

Our office will submit your Medicare charges to Medicare and your secondary insurance. You are responsible for deductibles and co-pays, as well as non-covered services. The balance of your account must be paid within 30 days unless other payment arrangements have been made.

Assignment of Insurance Benefits:

Patient (responsible person) irrevocably assigns and transfers to **Vista Family Medicine** all right, title and interest to medical reimbursement benefits under any and all applicable medical insurance policies covering patient, for the payment of hospital and medical care being provided. Patient (responsible person) authorizes payment directly to **Vista Family Medicine** of said medical reimbursement benefits.

NSF Checks

Returned checks will be issued a $30.00 NSF fee.

Overdue accounts:

We reserve the right to charge a fee for overdue accounts after 60 days. Delinquent accounts will be assessed a 1.5% interest charge per month unless payment arrangements have been arranged. We reserve the right to turn your account over to a collection agency if necessary.

Agreement to Pay Balance:

In the event that said medical insurance coverage is not sufficient to satisfy the charge in full, patient (responsible person) acknowledges that the resulting balance is not covered by this assignment and agrees to be fully responsible for the payment of any balance due. For any non-contracted insurance carriers, **Vista Family Medicine** will submit a courtesy claim and if no payment is received in 60 days, the balance will become patient responsibility. In the event charges are not paid, due to authorization or pre-certification denials, patient acknowledges the charge is considered a non-covered service and agrees to be fully responsible for payment of any balance due.

No Show Fee

Cancellations of appointments must be done 24 hours prior or this will incur a $25.00 missed appointment fee. Canceling your appointment with advance notice helps our office to utilize our appointment slots for open access scheduling.

I have read & agree to the Financial Policy and understand my financial responsibilities under this policy.

X________________________________
Patient Name

X________________________________
Date

X________________________________
Patient or Parent/Guardian Signature

If the patient is a minor and you are the responsible party, please provide us with the following information.

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Responsible Party Name & Date of Birth

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Responsible Party Social Security #

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Responsible Party Address & Phone #

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Please check the appropriate description of your relationship to the patient:

☐ Self ☐ Parent/Legal Guardian of Minor ☐ Other (Please explain______________)