Welcome to Piedmont Family Practice

Patient Information

Last _____ First _____ MI _____ Prev. _____

SSN: _____ DOB _____ Sex M or F

Billing Address

Street_____ Apt# _____

City _____ State_____ Zip _____

Physician _____ Marital Status _____

Home Phone _____

Work Phone _____

Cell Phone _____

E-mail _____ May we contact you through E-mail? Y or N

Special Fees

To cover costs and keep fees reasonable for all patients, we may charge for:

- After hours services (FDOCs) - $50.00
- Missed appointments - $50.00 - $100.00
- Returned checks - $25.00
- Delinquent balances, collection efforts – 25% of outstanding balance
- Copying of medical records – will be charged by Healthport
- Completion of lengthy forms, applications, letters, etc. - $10.00 - $30.00

OUR FINANCIAL POLICY

Thank you for seeking health care services from Piedmont Family Practice. Our highest priority is to provide you and your family with quality health care. Covering the cost of that care continues to be a challenge for patients, employers and provides. Since payment for health care services has become increasingly complex, we find it helpful to have a policy to guide us all. Please review our policy and sign a copy for our records. If you have any questions, please ask.

Payment For Services

If you have insurance coverage, we will file a claim to your insurer requesting that they reimburse us for the services you received. You need only to pay your co-pay, co-insurance, and/or deductible (if any) **at the time of service. (As required by many plans, your co-pay may be collected when you check-in.)** You will then be responsible for any balance unpaid by your insurer. If your insurer mistakenly sends reimbursement for our services to you, we ask that you promptly forward those funds to us to cover the services you received. **We must see proof of your insurance at each visit.**

If you have insurance coverage in which our practice does not participate, we will file a claim to your insurer as a courtesy to you, but you are ultimately responsible for payment of the services rendered to you.

If you have no insurance coverage, you are obligated to make payment for **all** charges at the time of service.

If you are seen for work-related injuries and are covered under a Worker's Compensation Plan, we will seek payment from that plan as long as you provide us with the necessary authorization and information from your employer at the time of service. **Otherwise, you are obligated to make payment for all charges.**

If you are seen as a result of a motor vehicle accident and plan to seek coverage under your insurance plan, the above policy regarding insurance coverage applies. However, if you plan to seek coverage from either an auto insurance policy or from a third party, **you are obligated to make payment for all charges at the time of service.**

If you are seen for services requested by a school, camp, employer, insurance company, or other such 3rd party, you are obligated to make payment for all charges at the time of service (most health insurance companies do not cover such services).

If you are unable to make payments which you may owe, our Billing Office will assist you in making special payment arrangements, when possible.

For your convenience, we accept cash, checks, major credit cards (MasterCard, Visa, Discover, American Express), and debit cards. If you pay with cash, you should retain your receipt for your records.

Lab Fees

Any lab specimens we process will be billed by the practice. Any lab specimens processed at outside reference labs will be billed by those reference labs. (Your insurance company, if any, dictates which reference lab we must use. If you do not updated us o your current insurance coverage, your specimens may be sent to the incorrect lab, resulting in fees for which you will be responsible).

Referrals

Many managed care plans require "referrals" from your primary care physician to see specialists or perform tests. Many plans will hold you financially responsible if you receive services without following your protocols. **Please familiarize yourself with your plan.** We have staff and protocols in place to help you obtain any necessary referrals. If you require a referral, please ask for assistance. (You will be financially responsible for referrals we give you in error based on inaccurate or outdated insurance information. It is very important that you keep us updated on your current insurance coverage and any changes).

Insurance Limitatations

If you have health insurance, note that each insurance plan varies regarding whether or not a particular service is covered, and if so, to what degree and under what circumstances. Again, since you are financially responsible for any services you receive which your insurance company does not cover, it is very important that you familiarize yourself with your plan.

Acknowledgment of Receipt of Financial Policy

I understand payment is expected when services are rendered. If my account becomes delinquent and requires submission to outside collection, I agree to pay any additional fees to cover collection costs, court costs, and attorney fees.

I have read, understand, and agree to adhere to the policies set forth above.

Signature Date

Acknowledgment of Receipt of Privacy Notice

By signing this form I acknowledge that I have received, read, and understand Piedmont Family Practice's Notice of Privacy Practices

Signature (Patient or Authorized Representative) Date

Insurance Coverage & Authorizations

I hereby authorize Piedmont Family Practice and its providers to apply for benefits on my behalf for covered services rendered. I certify that the information I have submitted is correct. I further authorize the release of any necessary information, including medical information, to my insurance carrier. In the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration. A copy of this authorization may be used in place of the original. This authorization may be revoked by either my insurance carrier or me at any time in writing.

Signature (Patient or Authorized Representative) Date