valley MED
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Financial Policy Acknowledgement

In the interest of a good health care practice, it is desirable to establish an office and credit policy to avoid misunderstandings. Our primary responsibility is to help our patients enjoy a positive experience and provide excellent health care.

- Patients will need to provide our office with their social security number and health insurance card (if applicable) unless the total charge is paid in cash at time of service. Treatment may be postponed if patient does not furnish the items above.
- All accounts balances are due at the time of the visit (this includes co-pay, deductible, or percentage not paid by insurance). There will be a fee of $10.00 for those who are unable to pay their co-pay at the time of service.
- A 20% discount is extended to patients with no insurance coverage, but only applies when the visit is paid in full on the same day of the service.
- Insurance is billed as a courtesy to our patients. It is the responsibility of the patient to verify demographic and insurance information at every visit, and to inform the clinic of any changes. Any questions or disputes about the insurance policy, for example what treatment is covered and the patients out of pocket expense, will need to be resolved by the patient directly with their insurance carrier. Ultimately, the patient is responsible for the timely payment of their account.
- A fee of $15.00 will be charged if payment is not made by the due date listed on patient statement. There will be a charge of $25.00 for any NSF returned check.
- There will be a $100.00 charge for a missed appointment or canceling with less than 24 hours notice. Multiple missed appointments may result in scheduling limitations (scheduling the day you wish to be seen only) or discharge from the practice. The initial consultation appointment missed or NOT canceled with **24 hour** notice may result in the inability to reschedule or establish care at our facility. Appointment reminders are sent as a courtesy; however, it is the sole responsibility of the patient to be aware of their appointment date and time.

I have read Valley Med's credit policy and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts may be assigned to a collection agency and I may be charged a collection fee of up to $75.00. Also, if it becomes necessary to effect collections on any amount owed on this or subsequent visits; the undersigned agrees to pay for all costs and expenses, including attorney fees.

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Print Patient Name Date

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Responsible Party Signature