Integrative Family Medicine of Bend

Financial Policy Agreement

INSURANCE: We contract with the major Oregon companies and bill most insurance companies. Knowing your insurance benefits – including eligibility, covered benefits and medically necessary procedures is your responsibility; please contact customer service at your insurance company for questions regarding your coverage. You are responsible for any charges not covered by your plan.

- **PROOF OF INSURANCE**: All patients must furnish valid and up-to-date proof of insurance coverage. If you provide false or expired insurance information you will be responsible for the balance of the claim. ***Please notify us of any changes in insurance coverage as soon as possible.*** Insurance denials for termination of coverage will be automatically billed to you.
- **CO PAYMENTS AND DEDUCTIBLES** All co-payments must be paid at the time of service. By contractual law your insurance company requires us to charge for, and you to pay for, all required co-payments, co-insurances, deductibles and non-covered services.
- **CLAIM SUBMISSION:** We will submit claims to your insurance and assist you in any way reasonable to help get your claim paid. Your insurance company may need you to supply information directly to them. It is your responsibility to comply with their request in a timely manner. Your insurance is a contract between you and your insurance; not us and your insurance. Please be aware the balance of your claim is your responsibility to pay whether or not your insurance company has paid.
- **REFERRALS:** If your managed care plan requires approval or authorization for referrals to a specialist, radiological imaging, medical facility care, etc., it is your responsibility to inform the office of this requirement ***prior*** to referral. We require 72 hours notice to facilitate a referral request and cannot issue retroactive referrals.
- **OUT OF NETWORK CARE**Please be aware that you have an option to seek care from Physicians even though they are not participating in your network. In this situation, your out-of-pocket expense will be greater. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance.
- **LABS/DIAGNOSTICS/PHARMACIES:** **PLEASE NOTE** Lab work, X-rays, referrals and all pharmacies including mail order pharmacies are NOT billed by IFM Bend. You are responsible for any and all charges/costs associated with those outside organizations for making payment arrangements with them. We recommend you check with those agencies regarding costs and consult your insurance policy for your benefit information.
- **WORKERS COMPENSATION / MOTOR VEHICLE ACCIDENT:** FCIM provides treatment for established patients for both work- related injuries and automobile accidents. The patient is responsible for providing us with timely billing information for treatment of these injuries. Patients who are being seen for workers compensation or for a motor vehicle accident claim, will be responsible for any services that are denied. Your claim with the insurance company does not guarantee payment.
- **MISSED APPOINTMENTS:** If you miss or cancel your appointment with less than a 24hr notice, our office reserves the right to bill you $50.00 for each no show or late cancelation. The fee will be your responsibility and will not be billed to your insurance.
- **PATIENT BALANCE:** After your insurance has processed your claim, we will mail you a patient balance statement. Payment in full is due upon receipt of this statement. If you have any questions or dispute the balance it is your responsibility to contact our billing office within 30 days. Past due balances are subject to collections and may be referred to a credit bureau and/or collection agency. If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule.
- **RETURNED CHECKS**: The charge for a returned check is $27.00 payable by cash, debit/credit card which will be applied to your account. Your bank may impose charges as well. We reserve the right to no longer accept checks from a patient at any time.

I have read, understood, and agree to Integrative Family Medicine of Bend's Financial Policy Agreement. I authorize the release of any information my insurance company may need to process my claim, and I authorize my insurance company to issue payment directly to Integrative Family Medicine of Bend. In the event I have a personal balance owing, I will promptly pay balance to bring account current. Failure on my part to pay my personal financial obligations to Integrative Family Medicine of Bend could result in my account balances being turned over to collections. I agree to pay any accounting service charges assessed by the billing department on balances over 60 days.

COPY AVAILABLE UPON REQUEST

Patient Signature (or responsible party for patient) Date