



Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**FINANCIAL POLICY**

Thank you for choosing My Family Physicians as your health care provider. We are committed to quality patient care at the lowest possible cost. The following is a statement of our financial policy that we require you to read and sign to any services being rendered. Please be aware that some, and perhaps all, of the services provided may be non-covered services that are not considered reasonable and necessary by your insurance carrier.

**Participating Insurance plans**

For those plans with which we are participating providers, all co-pays and deductibles are due at the time of service. To properly bill your insurance company and avoid ultimately delays, we require that you provide us with accurate insurance information and allow us to maintain a copy of your insurance card on file. In the event that your insurance coverage changes to a plan with which we do not participate, refer to the following paragraph.

**Nonparticipating plans**

For those plans with which we do not participate, we do not accept assignment of insurance benefits and we do not bill your insurance company. Payment is expected at the time of service. Your policy is a contract between you and your insurance company.

**Minors**

A minor must be accompanied by a guarantor for his or her account (the parent or guardian of the minor or other adult accompanying the minor during each visit).

**Authorization to pay benefits to physician/clinic**

I hereby assign payment directly to My Family Physicians to release any information acquired in the course of my examination or treatment to my referring physicians and/or my insurance company.

**Appointments**

Appointments are made by calling the office at (305) 960-7978. We realize that schedules change and that it may be necessary for you to cancel or reschedule an appointment. We request that you notify us at least 24 hours before the scheduled appointment for any such change, otherwise you may be charged a no show fee for the service scheduled.

**Emergencies**

If you are experiencing an urgent situation, please call the office at (305) 960-7978 and leave a message. We will return your call as soon as possible. If you are experiencing an emergency and need rapid attention for your safety or someone else's, do not delay waiting for a call back from us. You may call 911, or report to the nearest hospital emergency room.

**Fees and Payment**

**Copayment is always due at time of services.**

Additional Fees:

\$39.00 for RETURN CHECKS

\$35.00 for FILLING OUT FORMS (such as FMLA, DISABILITY, LIFE INSURANCE, etc.)

\$35.00 for RECORDS COPIES

\$25.00 for NO SHOW/BROKEN APPOINTMENTS WITH NO ADVANCED NOTICE

Patient's/Legal Guardians Signature: \_\_\_\_\_ Date: \_\_\_\_\_