Patient Name: _____ DOB:_____

Thank you for choosing our practice for your medical needs. We value our relationship with you and want to serve as your "personal medical home."
Unfortunately, because of your insurer's payment policy, in some cases we may have to complete your wellness care and your illness care in two separate visits. If you have a health problem you want to discuss with your doctor during your well visit, the doctor may decide to treat that problem and ask you to schedule another appointment for your well visit.
We realize the inconvenience this may cause and regret that your insurer's payment policy has led us to make this business decision. Your understanding of this situation is appreciated.

Payment Policy
We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but we cannot verify the plan is active for your visit, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. We must obtain a copy of your driver's license/ID and current valid insurance to provide proof of insurance.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If this is to occur, you will be notified by regular or certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Late appointments. To help us to serve you better and to allow us to see all patients at their scheduled times, anyone who is 8 minutes or more late to their appointment will be asked to reschedule. No-Show appointments may be charged a $30 fee.

9. Payment options. Morning Light Family Medicine accepts cash, and major credit and debit cards for payment. A $15 fee for returned checks will be applied.
Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines. I hereby assign the benefits from my insurance or any third party to Morning Light Family Medicine for services provided to me.

_____ _____

Signature of patient or responsible party **Date**