Clayton Medical Associates, P.C.

Name (Please Print) _____

Please initial each line to acknowledge that you have read and understand our office policies. These guidelines are in place to provide our patients with the highest level of care and service.

_____ If our office is not filing insurance for you, full payment is due at time of service.

_____ If we participate in your insurance, you are required to pay for all co-payments at the time of your visit. In the event that there is any remaining balance due after the claim is processed, you will be billed for the balance.

_____ It is your responsibility to know how your insurance policy works. We are not responsible for notifying you that charges or procedures will be applied to your deductible or that you may be responsible for a percentage. Unfortunately, all plans are different and we cannot know the details of your plan.

_____ We will ask to see your insurance card at every visit. We do this so that we can bill correctly. We need to review the card even if it has not changed. If you don't have your most updated card and the charges for your visit are denied by your insurance company, you will be responsible for the balance of the visit.

_____ You will be mailed a bill for any balance on your account. This bill will be due immediately upon receipt. If the bill goes unpaid for 60 days, your account will be forwarded to Midwest Collection Support Services. In addition, a 35% collection fee will be added to the outstanding amount that is owed to our office. Attorney fees, court costs, and collection fees incurred in an effort to enforce payment will be the responsibility of the patient/ guarantor. **No additional contact will be made by our office. In addition once your account has been turned over to the collection agency, there will be a 30 day period in which our office will be available to assist you only in the event of a true medical emergency. No requests for medication or appointments after the 30 day period will be honored.**

_____ We accept cash, check, Visa, MasterCard and Discover. A $35.00 charge will be assessed for all checks returned by your bank.

_____ We ask for at least a 24 hour notice for all cancellations. We understand that some emergencies are unavoidable. Our goal is to offer your appointment to someone who needs it, and we cannot do this if cancellation is not done in a timely fashion. If you miss your appointment or do not cancel with sufficient notice there will be a $50.00 charge.

_____ As a courtesy, we try to confirm your upcoming appointments. Circumstances don't always allow us to reach you. Please don't count on a call from us to remind you of an appointment. If you have any questions about the date or time please call.

_____ **If your insurance requires a referral from your Primary Care Provider, it is the patient's responsibility NOT THE OFFICE'S to keep track of them and make sure they are current. If you don't have a referral you will be asked to reschedule your appointment.**

Your signature below signifies your understanding and willingness to comply with these policies and procedures.

_____ Date_____
Signature of Patient or Responsible Party

_____ Date_____
Staff Witness Signature