

PATIENT FINANCIAL POLICY

Thank you for choosing the Medical Center as your healthcare provider. We are committed to providing healthcare services in the tradition of personable, responsive and highly skilled professionals. As a part of our professional relationship, it is important that you have an understanding of our Financial Policy.

All patients/responsible party must read and sign this form prior to receiving services.

- **It is your responsibility to provide us with your most current insurance information.**
 - If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for the charges for the services rendered.
 - Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.
 - Before receiving services, you must verify that we are participating providers for your insurance company. In the event we are not participating providers and the physician you are seeing is not listed with your insurance company, your insurance company will process your claim as “out of network”. “Out of network” payments by your insurance are less and will result in you being financially responsible for a larger portion of the charges for the services.
 - We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. **You are financially responsible for services not covered by your insurance plan.**
 - We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company’s arbitrary determination of usual and customary rates.
 - Copayments are due at time of service. Any charges that are applied to your deductible or are not covered by your insurance are your responsibility. The amount you owe is based on information and payments we receive from your insurance company.
 - If you do not have insurance, you will be responsible for payment at the time of your visit. If you cannot pay the total charges, you will need to contact our business office to discuss arrangements for payment of the unpaid balance.
- **It is your responsibility to provide us with your most current billing information.**
 - You must provide your most current billing address, all available telephone numbers and other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information. You will be asked to verify your current billing information each time service is rendered.
 - We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30-days after receipt of the initial statement. You can call (620) 669-6690.
 - **Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 60 days of the initial statement issue date are deemed past due. Past due balances will be subject to a 1% monthly late fee and may be referred to a professional collection agency and/or attorney for further collection activity. Your account may be placed on a pre-pay basis until your account is current.
 - If you are not able to pay the balance due in full, you must contact our business office to discuss the payment of your account balance. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney.
 - If your account is referred to a professional collection agency and/or attorney, you will be responsible for all collection costs incurred, including attorney’s fees and court costs if applicable
 - In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add a \$30.00 return check fee to your account. Also, we may seek all additional legal remedies provided to us under Kansas law.
 - Failure to keep your account balance current may require us to cancel or reschedule your appointment.

Full payment is due upon receipt of statement. We accept cash, checks, money orders and VISA and MasterCard credit cards.

I have read and understand and agree to the terms of this Financial Policy.

Signature of Responsible Party

Date

Patient Name: _____ DOB: _____

Chart # _____