Horizon Family Medicine, PA
Five Locations With One Purpose . . . Your Health
www.horizonfamilymed.com

FINANCIAL POLICY

Legal Name (First, Middle, Last): _____ Date of Birth: _____

This form is to outline our policy regarding payment for services. Please take the time to read it carefully. We will be happy to answer any questions you may have. Payment for service, including all copayments and deductibles, is due at the time service is provided in our office. We accept **cash**, **checks**, **Visa, MasterCard and Discover.** You must bring your **insurance cards,** including any **Medicare** and **Medicaid** cards, and your **state-issued photo ID** (driver's license) to your appointments.

For patients with Insurance: If proper and complete paperwork is provided to us **prior** to services being rendered, we bill most insurance carriers for you. Incomplete information may result in claim denial for which you will be financially responsible. If your plan requires any pre-authorization for services, you are responsible for obtaining this prior to being seen. Failure to do so may result in claim denial for which you will be financially responsible. In the event that your insurance carrier does not pay on your charges within a reasonable period of time, you will be responsible for the full balance due on the account. This includes all costs associated with collection efforts including but not limited to collection agencies, legal and attorney fees.

For patients with Medicare: We will bill Medicare for you. All copayments and deductibles are due at the time of service. In the case of services not typically covered by Medicare, you will be given the option to receive the services at additional cost to you. This is outlined in the Medicare Advanced Beneficiary Notice which you must sign.

For patients with Medicaid: We will bill Medicaid for you. All coverage information must be complete and correct.

For self pay patients: Payment for service is due at the time of service. We can provide an estimate of our fees prior to services in the office. This is only an estimate and the actual amount may be higher or lower.

There is a $25.00 fee for returned checks.

PRIVACY INFORMATION (HIPAA Policy)

I authorize Horizon Family Medicine to contact me and/or to leave telephone messages for me at the following telephone numbers:

Home Phone: _____ Work Phone: _____ Cell Phone: _____

I authorize Horizon Family Medicine to contact me via EMAIL: _____

I authorize Horizon Family Medicine to release my medical information to the named persons or organizations listed below:

❑ Spouse (Print Name):_____

❑ Parents (Print Names):_____

❑ Children (Print Names):_____

❑ Other (Print Names and Relationship to the Patient):_____

READ & SIGN BELOW

I have read, understand and agree to the above financial policy for payment of fees. I agree to pay the balance owed on my account including costs associated with collection efforts. I understand that I am ultimately responsible for payment of all professional fees.

I acknowledge that, in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a copy of the Horizon Family Medicine Notice of Privacy Practices has been made available to me. It is also available at www.HorizonFamilyMed.com

_____ _____

Signature of Patient (or Legal Guardian) **Date**