OAKSTONE HEALTH CENTER FINANCIAL POLICY

Thank you for choosing us as your care provider. We are committed to providing you with the best possible medical care. Please understand payment of your bill is considered a part of your treatment. The following information is provided to avoid any misunderstanding or disagreement concerning payment for services provided by our office.

1. Our office participates with a variety of insurance plans. It is your responsibility to:
   - Bring your current insurance card to every visit and notify us of changes in coverage.
   - Be prepared to pay your co-pay at each visit. Payment can be made by cash, check, MasterCard or Visa.
   - Understand that your insurance carrier can choose to assign benefits to Oakstone Health Center or make payment directly to you. If payment is made directly to you, you must remit that payment to Oakstone Health Center.
   - I understand and certify that I am financially responsible for all health care service charges that are paid to me directly by my insurance carrier, as well as for any applicable co-payment, co-insurance, deductible, and/or charges for non-covered services provided to me or any of my dependents.
2. We will submit a claim to your insurance company for you. Balances not paid, per our contract by your primary insurance company may be billed to your secondary payer. A monthly statement will be sent to you. Ultimately you are responsible for payment of charges.
3. If you have questions about your insurance, we are happy to help you. Specific coverage issues, however should be directed to your insurance company's member services department (number should be on your insurance card).
4. The office charges for all services that are significant and separately identifiable. Patients that are seen for physical exams and require other treatment for illnesses or problems may be charged separately for each service even when both services are provided on the same day.
5. The office can only code and file a claim for a patient's visit with a diagnosis that was encountered and documented in the medical record. To request a diagnosis change solely for the purpose of securing reimbursement from the insurance carrier is inappropriate and could be considered a fraudulent act.
6. If you do not have insurance, you have a high deductible plan, or if you are insured by a company with which we are not contracted, payment in full is expected at the time of service unless payment arrangements are made and kept.

7. All balances billed are due within 30 days of the statement date. Unpaid balances greater than 30 days are subject to our collection process. Accounts sent to our collection agency are subject to a collection charge of $50.00 for balances up to $150.00 and for balances of $150.01 and higher the fee is 35% of the outstanding balance. This fee is in addition to the balance owed.
8. Any accounts that are sent through our collection process will be dismissed from the practice.
9. There will be a fee charged for all appointments that were not kept and/or not cancelled 24 hours prior to the appointment time.
10. Co-pays not paid at time of service may result in a processing fee.
11. There is a fee on all returned checks.
12. There is an additional fee for all office visits scheduled after posted hours. Emergency visits/walk-ins/non-scheduled appointments will be charged an additional fee.
13. There is a fee to copy any or all medical records.
14. There is a fee for FMLA and/or Disability forms. This is a per form fee to be paid prior to the forms completion.
15. If you miss or no show for three (3) appointments you may be dismissed form the practice.
16. There is a fee for prescription refills not requested 48 hours in advance.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

By signing below, I certify that I have read and understand the Oakstone Health Center Financial Policy and my responsibilities as a patient or parent/guardian of a patient. I will pay the Oakstone Health Center any co-payments, co-insurance, deductibles and/or non-covered services. I will immediately pay to Oakstone Health Center any payments that I receive from my insurance company for services provided to me or my dependents. I will also be responsible for any amounts not paid by insurance because I have not provided the appropriate insurance information for billing.

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PRINT PATIENT'S NAME DATE

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SIGNATURE OF PATIENT OR GUARDIAN

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WITNESS