



Financial and Insurance Policy

Thank you for choosing Lake Mary Family Physicians as your health care provider. As part of our services, we request you read and sign the following financial policy prior to services being rendered. Patient or responsible party must complete our information and insurance form before seeing our physicians or nurse practitioner.

- **Full payment, co-payment, percentages and/or deductibles are due at the time services are rendered.** Payment methods are: Cash, Checks, MasterCard, Visa and Discover. If you do not have your fees with you at the time of service we have the right to reschedule your appointment. Please bring your insurance card, copy of your driver's license and your portion to pay with you. _____ Initials
- **Returned Checks:** A \$25.00 service charge will be applied to your account for returned checks. Returned checks will not be re-deposited. All balances must be paid in cash or by credit card. One attempt will be made to collect this debt from the patient, if not collected within 5 days of the returned check; the account will be turned over to a collection agency. We request a copy of your driver's license for our records for verification. _____ Initials
- **Office Policy:** Per our contracts with each insurance company, it is your responsibility to know your benefits. Insurance is billed as a courtesy to our patients; however, the patient is the final responsible party. Your insurance company doesn't guarantee your benefits until the claim has been filed. If your insurance has not paid within **60 days** you will be responsible for the balance. Your insurance will send you an explanation of benefits that explains what they have paid to our office. If you do not agree with their payment, please contact the insurance company directly.
- **Appointment Cancellation Policy:** A **\$35 fee** will be charged for scheduled appointments cancelled **without 24 hours** prior notice and **will be charged** for failure to show up for a scheduled appointment. *If you have two missed no show appointments you will be dismissed from our practice.* _____ Initials
- **Minor Patients (under the age of 18):** The adult accompanying a minor (patient/guardian) is responsible for full payment at the time of service. For unaccompanied minors, payment arrangements need to be made in **ADVANCE** and we must have parents or guardians written permission along with a copy of their photo I.D. prior to treatment of a minor.
- **All Medicare Patients:** We will bill Medicare as well as secondary insurance. If you have Medicaid as a secondary insurance we will **not** be able to see you. If payment is not received from your secondary insurance within **60 days**, you will be notified that there is an outstanding balance due. You must then contact your secondary insurance to receive reimbursement for any fees paid directly to our office.

Please realize that:

1. **Your insurance is a contract between you, your employer and the insurance company.**
2. **You are responsible for all charges that are denied/not covered by your insurance company. Procedures/services performed by our physicians, nurse practitioner or nurses may not be covered under your insurance plan.**
3. **Although we verify your coverage through your insurance company with each and every patient, verification of benefits is not a guarantee of payment from your insurance company. We request that you present a copy of your insurance card for our records that is being utilized.**
4. **If you are sent outside of the office for additional testing such as lab work or imaging, that facility will file your insurance for you. If you have questions regarding billing or claim payment, call the facility directly. We do not have information regarding billing from outside of this office.**

Print Patient's Name: _____ Date: _____

Print Name of Parent/Legal Guardian: _____

Signature of Patient or Legal Guardian: _____
