Patient Name: _____

FINANCIAL POLICY AGREEMENT

To Be Completed By Patient/Responsible Party

This is an agreement between Complete Care Center and the Patient named on this form. In this agreement the words "you," "your," and "yours" mean the Patient. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Complete Care Center. By executing this agreement, you are agreeing to pay for all services that are received.

We must EMPHASIZE that as medical care providers, our relationship is WITH YOU and not with your insurance company. While the filing of most insurance claims is a courtesy that we extend to our patients, the charges are legally your responsibility from the date the services are rendered. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

Initial each section

____ **Contracted Insurance:** Not all services are a covered benefit in all insurance benefit packages. There are over 500 different insurance benefit packages in Michigan. Insurance brokers, Insurance company representatives and our staff cannot humanly keep track what your benefits will be at any given time. Therefore, there may be additional charges that will be your responsibility due after your claim is processed by your insurance company according to your specific benefit package.

____ **Non-Contracted Services:** Not all physicians participate in every insurance plan. It is your responsibility to confirm that our office participates with your insurance package. You may incur charges that your insurance company does not cover as "Out of Network" or "Non-Participating". These are generally higher deductibles, co-pays and/or co-insurances

____ **Reimbursement:** Insurance companies base reimbursement on an allowable fee schedule, which changes periodically. We collect payments based on the current allowable fee schedule as of your date of service. Some insurance companies arbitrarily select certain services they will not cover or that they bundle with other services. Your insurance company can change to exclude or bundle prior benefit coverage at any time.

____ **Required Payments**: Payment for services rendered, deductibles, co-pays, and/or co-insurance is expected at the Time of Service.

____ **Billing Fee:** Patients who do not pay for services rendered, deductible, co-pay, and/or co-insurance at the time of service will incur a $25.00 billing fee.

____ **Finance Fee**: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The Finance Charge will be computed at the rate of two percent per month each month or an annual percentage rate of twenty-four (24%) percent. The finance charge on your account is computed by applying the periodic rate (2%) to the "overdue balance" of your account. This is the balance owed and then subtracting any payments or credits applied to the account during that time.

____ **Returned Checks**: Declined credit cards on an automatic payment plan contract and any returned checks will incur a $25.00 administrative collection fee.

Initial each section

____ **Missed Appointments:** Failure to show for a scheduled appointment without 24 hours prior notice of cancellation regardless of when the appointment is made (including same day appointments) will result in a $30.00 administrative charge.

____ **Prescription Fees**: Prescriptions for medication handled outside a regular office visit (called in, written or changes) will incur a $10.00 administration fee for up to 2 drugs or less. 3 or more drugs will incur a $20.00 administration fee. Fee is to be paid before the prescription is called in or written. **Please note that it takes 24 – 48 hours to handle these requests.**

____ **Divorce:** In case of divorce or separation, the party legally responsible for the account prior to the divorce or separation remains responsible for the account after. After a divorce decree or separation, the parent authorizing treatment on patient router for a minor will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the parent's responsibility after signing the patient router to pay the charges for that day and to get reimbursed from the legally responsible parent. We will not get involved in these situations.

____ **Transferring of Records:** You will need to request in writing, and pay copying fees if you want to have copies of your records sent to another doctor or organization. The amount of the fees is dependent on the number of pages we need to copy and is based on the Michigan Medical Records Access Act and that fees change annually. You authorize us to include all relevant information including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information including your payment history.

____ **Past due accounts**: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred, if we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs. In case of suit, you agree the venue shall be Grand Blanc Circuit Court.

____ **Credit History:** In the event that your account becomes past due, your credit and/or employment history may be checked and your account submitted to a collection agency and/or credit reporting bureau.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement is in full force and effect

Patient's Name: _____ Responsible Party (if not patient)(Print): _____

Patient/Responsible Signature: _____ Date: _____ Initials: _____