ROIS MEDICAL GROUP
HEALTH & WELLNESS

FINANCIAL POLICY STATEMENT

The policies listed herein have been approved by management with the goal of providing the finest care and services to our patients. Care delivered by this office will be administered regardless of race, color, social status, national origin, handicap or gender.

We are committed to providing you with the best possible care. In order to accomplish this, we need your assistance in reading and understanding financial responsibility and our payment policy.

RESPONSIBILITY FOR THE BILL

It is the expectation that all patients/guarantors receiving services are financially responsible for the timely payment of the charges incurred. While the office will file, verified insurance claims for payment of the bill(s) as a courtesy to the patient, the patient/guarantor is ultimately responsible for payment and agrees to pay the account(s) in accordance with the regular rates and terms of the practice in effect at the present time

COLLECTIONS

Payment for service is due at the time the service is rendered and non-emergency services may be declined until the necessary payment arrangements have been accomplished.

Payment will be accepted in checks and all major credit/debit cards. We will be happy to file verified insurance on your behalf. For your convenience if your check is dishonored or returned for any reason, we will electronically charge your account the amount of the check plus a processing fee of $50.00.

Patients paying out of pocket for the services rendered are considered self-payments. Payment is due at the time of service, $**150.00** for Initial Consult and **$120.00** for follow ups, any additional service payments will be determined at the time of your visit.

PAYMENT ARRANGEMENTS

The practice will make a reasonable effort to assist patients in meeting their financial obligations. Financial arrangement for payments will be made at the office's discretion, based on the amount of the patient's liability and the patient's ability to pay based on completed credit application.

ACCEPTANCE OF INSURANCE

The practice will accept "Assignment of Benefits" on verified insurance policies and submit a bill to carrier on the patient's behalf. It is understood that insurance is filed as a courtesy to the patient and does not relieve the patient of financial responsibility. Claims filed will be held 45 days pending payment. The patient/guarantor will be responsible for payment in full on all the claims not paid within the allowed period of time.

RELEASE OF INFORMATION

By signing our release of information form, you provide us with the authority to release such information as is necessary to collect from insurance companies and other third party payers.

NO SHOW POLICY

The practice will charge a **NO SHOW fee of $50** and will deny any further appointments from the patient that does not show **twice**, to any type of appointment (does not show up without notice). This policy is non-negotiable as we are dedicating precious time to patients in need every day.

MEDICAL RECORDS FEE

Florida Statutes 395.3025: Exclusive charge for copies may include sales tax and actual postage. Non-paper records not to exceed $2.00 per page. Paper records not to exceed $1.00 per page. A fee of up to $1.00 may be charged for each year of records requested.

Our practice will charge **$1 for every printed page** of any medical record, lab and or diagnostic image that the patient requests and it will available for pick up at the office up to 48 hours after it was requested.

BAD DEBTS/LEGAL ACTIONS

If the account is not paid in full or satisfactory arrangements made within the allowable time frame, the practices reserves the right to refer the account to an attorney and/or a collection agency for collections of the balance.

I agree to assume responsibility for all charges incurred should collections of this balance become necessary including court costs and attorney's fee.

The administration and management welcomes the opportunity to discuss any aspect of the financial policy. We appreciate your confidence and strive to provide quality healthcare.

I have read the *Financial Policy Statement* and understand regarding above.

_____ _____

Patient/Guarantor Date

_____ _____

Witness Date