THE FAMILY HEALTH CENTERS
ASHEVILLE | ARDEN | HOMINY VALLEY

MR#:_____

Please review this financial policy and sign in the space provided.

1. We participate with many insurance plans, including Medicare. Please check our website for our participation list. If your insurance plan is not listed, payment in full is expected at time of service. Understanding your insurance and what it will pay for is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. Co-payments and deductibles are due at time of service. We accept, cash, check, debit and major credit cards, including Care Credit
3. Please be advised that some services you receive may be designated as non-covered or not medically necessary by Medicare or other insurers. Payment for these services is also expected at time of service.
4. If you do not have insurance we will provide a 30% discount on select services *ONLY* if payment in full is made at the time of the visit.
5. Please fill out all forms provided and present your driver's license and current insurance card at the time of your visit. If you fail to provide the correct insurance information in a timely manner, you may be responsible for payment of the bill.
6. We will submit your claims to the insurance company in a timely manner and represent you as best we can. Your insurance company may need information directly from you in order to pay your claim. Remember, whether or not your insurance pays a part of the claim, it is ultimately your responsibility to see that the balance is paid.
7. If your insurance changes, please notify us before your next visit so we can make the change in our system.
8. If your account is over 90 days past due, you will receive a letter giving you 15 more days to pay the account in full. If payment is not made within that time your account may be turned over to a collection agency and you may be dismissed from the practice. If this is to occur, you will be given 30 days to find alternative medical care. During that 30-day period our physician will only be able to treat you on an *emergency* basis.
9. It is *YOUR* responsibility to provide us with your most current mailing address, phone number and insurance information. If we receive returned mail and are not able to contact you, it is likely your account will be turned over to a collection agency for further attention.

   Our practice is committed to providing the best treatments to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for reading and signing this collection policy. Please let us know if you have any questions or concerns.

I have read and understand the financial policy and agree to abide by it.

_____ _____ _____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY SIGNATURE OF FHC EMPLOYEE DATE