FINANCIAL POLICIES

FAMILY MEDICAL CENTER
Rocky Mount
An Affiliate of Generations Family Practice

FINANCIAL POLICY

- Patients must arrive at their scheduled appointment with their insurance card, and insurance copay if applicable. **Co-pays required by the patient's insurance plan must be paid at the time of service.**
- Patients with **deductibles** will be responsible for paying **$150** of their bill at the time of service.
- The patient is ultimately responsible for all charges associated with their medical care regardless of insurance coverage.
- Family Medical Center of Rocky Mount providers participate in a large variety of insurance plans; accept assignment and are participating providers with Medicare. If the patient has an insurance plan that Family Medical Center of Rocky Mount providers do not participate with, the patient will be expected to pay **$150** of the charges on the day of the visit. We do not file out-of-network claims.
- We participate with Medicare. We will file Medicare Advantage plans as a courtesy to our patients. There are some Medicare Advantage plans that we are not contracted with and you could be charged a deductible if we are considered out-of-network. If you are unsure, please ask if we are in-network with your Medicare Advantage Plan.
- Patients that do not have insurance coverage and/or cannot provide proof of insurance at the time of service will be considered self-pay. New self-pay patients will be required to pay $150 prior to being seen. If the patient is not prepared to pay this, then the appointment is rescheduled, and a payment of $150 will be expected at the newly scheduled appointment. The $150 payment will be applied to your charges for your new patient visit and you will pay any balance over the $150 at the time of check-out.
- You will be billed in full for services that your health plan deems to be non-covered services; any balances due after we have received payment from your insurance carrier and/or balances for self-pay services and supplies or if your insurance is inactive.
- All balances are payable within 30 days of receipt of the patient statement.
- We accept cash, checks, and all major credit cards. Payments can be made online at www.rmfmc.com.
- A $30 return check fee will be assessed to your account for any check returned as not payable.
- Family Medical Center of Rocky Mount reserves the right to submit any patient account to collections if it is deemed that the account has been in default of payment obligations or compliance with this policy.
- A no-show fee of $50 will be charged for appointments not canceled or rescheduled at least two hours prior to the scheduled appointment time.

TIMELY FILING POLICY

- In order to properly file your insurance claim(s), we require that you provide us with your current health insurance card(s), including coordination of benefits if more than one insurance. If the patient is a child and is covered by both parents, we will need to know which insurance is primary. Usually, the parent whose birthday comes first in the year provides the primary insurance coverage.
- If you provide us with your current insurance card within ten business days of your visit, we will file your claim.

FINANCIAL POLICIES

TREATMENT OF A MINOR

- If the patient is a minor (under the age of 18) a parent/legal guardian must be present at each appointment.
- We must have a signed consent form on file if a parent or legal guardian does not accompany a minor child.
- The parent/guardian is responsible for all charges not covered by insurance.

ACKNOWLEGDGMENT

Our practice believes that good patient /provider relationships are based on understanding and good communication. If you have any questions about financial arrangements, please feel free to contact the Insurance/Billing Department. We will make every effort to assist you concerning your account.

By signing this form, I acknowledge that I understand the policies outlined within this document. In addition, my signature permits Family Medical Center of Rocky Mount to file claims to my insurance (if applicable). I also understand that I accept financial responsibility for all services rendered regardless of insurance coverage.

Print Name

Signature

Date / /