ASHLAND FAMILY PRACTICE

935 Siskiyou Blvd. Ashland, OR 97520-2143
Phone: 541 482 2716 Fax: 541 488 5461
Cynthia Parks-Landis, F.N.P. Jennifer Moss, F.N.P.
Rebecca Bolling, F.N.P.

FINANCIAL POLICIES

Thank you for choosing Ashland Family Practice as your medical provider. We have written this policy to keep you informed of our current financial policies.

NO INSURANCE

Payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make prior arrangements. When you pay in full at the time of service, we can offer you a "prompt pay" discount of 15%.

INSURANCE

Although we are contracted with several insurance companies, it is your responsibility to make sure that our provider is in your plan. It is also your responsibility to know your insurance benefits and inform us of any changes in your insurance coverage. This ensures accurate billing and referrals. As a courtesy, we will bill up to two of your insurances. We cannot become involved in disputes with your carrier regarding your benefits.

Co-pays are due at the time of service. It is your responsibility to know the amount of your co- payment. The co-pay cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier.

For your convenience we accept cash, checks, debit cards, Visa, MasterCard, and money orders. Payments are also accepted over the phone.

AUTO ACCIDENT

We will bill for motor vehicle accidents, but only as a courtesy. If your motor vehicle insurance carrier does not pay or does not pay in a timely manner, then payment in full is your responsibility. We will supply any information that may be needed for you to submit to your motor vehicle insurance.

LIABILITY INJURY

If your injury is a result from another party's negligence, you are required to pay for services and then collect from the responsible party. We will not file your insurance, but will provide you with a receipt to do so.

WORKER'S COMPENSATION

If your injury is due to an accident in your workplace, please inform the receptionist before you see the provider. It is your responsibility to know your employer's workers compensation insurance.

RETURNED CHECKS

There is a $25.00 return check fee on all returned checks.

ASHLAND FAMILY PRACTICE

935 Siskiyou Blvd. Ashland, OR 97520-2143
Phone: 541 482 2716 Fax: 541 488 5461
Cynthia Parks-Landis, F.N.P. Jennifer Moss, F.N.P.

BILLING If you have any questions about your bill, please call our billing department. For your convenience, our Billing Office is staffed Monday through Friday from 8:00 AM to 5:00 PM. The phone number is (541) 471-3799 option 2.

COLLECTIONS Accounts that are not paid within 30 days will begin our in-house collection process. If your balance is not paid monthly and in a timely manner, you may be subject to dismissal from the practice.

MEDICAL RECORDS We will provide you a copy of your medical records upon request, one time for no charge. Any further copies will require a fee. You will need to sign a letter of release prior to having them copied. Please allow up to 30 days for this request to be processed.

NO SHOW POLICY We understand that there are times when you must miss a doctor's appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment you may be preventing another patient from getting much needed treatment and/or disrupting the providers' schedule. We will allow a "one time" no show appointment. However, there will be a charge of $25.00 for every no show appointment after that. Insurance will not cover this charge it will be the patient's reasonability. Repeated missed appointments may result in your physician sending a letter discharging you from the practice. If this occurs, we will provide thirty days of urgent care only and transfer your medical records when you find a new physician.

ASSIGNMENT OF BENEFITS I hereby authorize my insurance benefits to be paid directly to the above signed physician, realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

ACKNOWLEDGMENT

I acknowledge that I have received and read a copy of the Ashland Family Practice financial policies.

Patient's Name (Please Print) _____

Signature/ Patientor Guardian_____Date_____