THE FAMILY HEALTH CENTERS
ASHEVILLE | ARDEN | HOMINY VALLEY

Date: ______________________

Please review this **Financial Policy** and sign in the space provided.

1. Please complete all forms provided and be prepared to present your driver's license and current insurance card at the time of your visit. It is YOUR responsibility to provide us with your most current mailing address, phone number and insurance information.

2. We participate with many insurance plans, including Medicare. Understanding your plan benefits and what services are or are not covered is your responsibility. If we provide services at a Wellness Visit that are not covered by your insurance or Medicare, extra charges and a copay may appear on your bill. Contact your insurance company directly for any questions you might have regarding your coverage.

3. Please check our website for our participation list. If your insurance plan is not listed, payment in full is expected at time of service.

4. Co-payments and deductibles are due at time of service. We accept: cash, check, debit and major credit cards, including Care Credit.

5. Please be advised that some services you receive may be designated as non-covered or not necessary by Medicare or other insurers. Payment for these services is also expected at time of service.

6. We submit claims to insurance carriers promptly. Your insurance company may require additional information directly from you to pay your claim. It is your responsibility to provide this as timely as possible. Whether your insurance pays all or part of the claim, it is ultimately your responsibility to pay any balance due after insurance processes your claim.

7. If your insurance coverage changes, please notify us before your next visit so we can make the change in our system.

8. If you do not have health insurance, the Family Health Centers offers a 30% discount on select services ONLY if payment in full is made at the time of the visit.

9. If a balance due on your account is 90 days or older, your account will be moved to a collection process. You will receive a final letter offering an opportunity to pay the debt. If payment is not made, your account may be turned over to a collection agency and you may be dismissed from the practice. If this occurs, you will be given 30 days to find alternative medical care. During that 30-day period your FHC provider will only be able to treat you on an *emergency* basis.

Our practice is committed to providing high quality care to the patients. Please let us know, if you have any questions or concerns.

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

______________________________	______________________________
Signature of Patient/Responsible Party	Printed Name of Patient/Responsible Party
______________________________	______________________________
Signature of FHC Employee	MR #

Updated July 2019