North Raleigh Family Medicine
8331 Bandford Way, Suite 101 ♦ Raleigh, NC 27615 ♦ Tel: 919-841-4566 ♦ Fax: 919-841-4568

FINANCIAL POLICY / PRACTICE INFORMATION

Thank you for choosing North Raleigh Family Medicine for your family's medical care. Our goal is to provide quality healthcare for you and your family. We intend to keep you well informed of office policies that may affect you. The following is a statement of the financial policies and practice information of North Raleigh Family Medicine, which we require you to read and sign prior to the initiation of medical care. If you would like a copy, please feel free to speak with one of our front office staff and they will be happy to assist you.

FULL PAYMENT, CO-PAYMENT, OR ANY OUTSTANDING BALANCE IS DUE AT THE TIME OF SERVICE.
WE ACCEPT CASH, PERSONAL CHECKS, AND MASTERCARD/VISA
CO-PAYMENTS THAT ARE NOT PAID WILL BE SUBJECT TO A $10.00 SERVICE FEE.

Insurance

In most cases we will accept your insurance benefits. Your portion of the bill (also known as co-payments/co-insurance or deductibles) is to be paid at the time of service. We cannot waive or discount this fee due to our contracts with insurance companies. If not paid, we reserve the right to charge a $10.00 service fee. **The balance is your responsibility whether your insurance company pays or not.**

We cannot file a claim to your insurance company unless you give us your insurance information. Please present your insurance card at the time of check-in. It is necessary for us to keep a copy of the card in your medical records chart. **We do not bill secondary insurance.**

Your insurance policy is a contract between you and your insurance company. **We are not a party to that contract.** Please be aware that some, and sometimes all, of the services provided may not be covered by your insurance.

In the event that a charge is not covered by your plan, you will be billed the balance after we obtain an Explanation of Benefits from your insurance carrier. Our practice is committed to providing the best medical treatment for our patients and we charge the usual and customary fees for the services rendered. Therefore, outstanding charges are due upon receipt. **Accounts with unpaid charges 90 days from the original date a claim has been filed, are placed with a collection agency. You will be responsible for any collection cost.**

Non-Contracted Insurance Plans

North Raleigh Family Medicine welcomes those patients whose insurance companies are not contracted with this office. We request payment at the time of service for all office visits and surgical procedures.

Returned Checks

There will be a $25.00 service charge for all returned checks.

Consent To Treat

I voluntarily consent to medical treatment under the professional judgment of Thomas L. Jeffries, MD and his staff. I understand that the medical treatment performed is necessary or beneficial to my condition.

Consent to Treat - Minor Patients

The parents, adult, or guardian accompanying a minor are responsible for services at the time of visit. You will be asked to complete a "Consent to Treat Minor" form for possible visits without the parent/guardian present.

OFFICE HOURS:

Monday – Thursday	8:00am – 5:00pm
Friday	8:00am – 12:30pm

APPOINTMENTS:

Urgent:	Expect an appointment within 1 (one) working day
Follow-Up:	Expect an appointment with 3 (three) weeks
Physicals:	Expect an appointment within 6 (six) weeks

Special Note: Chronic illness may require periodic office visits & blood work for proper management of your care.

PLEASE INITIAL (*page 1)*

AFTER HOURS CARE: **Emergency:** Call 911 or go directly to the emergency room as designated by your insurance company. **URGENT:** for urgent needs call (919) 604-5369 to reach the on-call provider.

ADVISE: Generally our office will return calls at the completion of the morning or afternoon schedule.

REFILLS: Call your pharmacy and ask them to fax refill request to our office @ 841-4568. DO NOT wait until you are out of medicine. Refill requests may take 24 – 48 business hours.

REFERRALS: If you have not discussed the referral with your provider, make an appointment to do so. Remember that our providers can handle most of your healthcare needs and will refer you to a trusted specialist whenever specialty care can improve your health. If you have chosen a managed care or HMO insurance provider, we are obliged to follow their guidelines.

LABORATORY: For our patient's convenience, LabCorp Lab is located in our office for your laboratory needs, insurances will be billed directly by LabCorp. It is your responsibility to understand your insurance plan, should there be any unpaid claims, you will receive a bill directly from LabCorp.

MISSED APPOINTMENTS: Please remember to call and cancel your appointment. Your failure to do so prevents another sick patient from being seen. Our policy is that twenty-four (24) hours notice is required. We charge a "NO SHOW" or "CANCEL WITH LESS THAN 24 HOURS NOTICE" fee of $50-$100 when you have failed to show or cancel an appointment. Repeated "no shows" may jeopardize future appointment availability.

MEDICAL RECORDS & FORM FEES We are happy to provide you with copies of medical records when needed, however, there is a fee for this service. The copying of medical records is ($0.75) per page for the first 25 pages and($0.50) per page for pages 26-100, and ($0.25) for each page in excess of 100 pages. When a provider needs to complete any forms/paperwork, there is an administrative charge of $20.00. These fees are payable upon request of service.

PATIENT CONFIDENTIALITY

I have read this office's PRIVACY POLICY PRACTICES and have received a copy if I so desire. _____

PLEASE INITIAL

CONTACT Any telephone numbers/email addresses given by you may be used to contact you regarding **personal** medical information and to reconcile your account. We may also contact you by sending text messages as necessary. Methods of contact may include pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I/We have read this disclosure and agree that the practice/authorized agent may contact me/us as described above.

REQUIREMENTS:

√ Arrive 15 minutes before your appointment time
√ Always bring your medications to your appointment
√ Always bring your insurance card
√ If you arrive more than 15 minutes late for your appointment; you may be asked to reschedule.

I have read, understand, and accept the above information.

X_____ _____
Signature of Patient Date

X_____ _____
Signature of Parent or Guardian Date