Financial Policy (Revised 2022)

Dear Patient:

The following are our policies so that you understand your responsibility regarding the charges for the services rendered to you by this office.

1. We understand that unexpected things come up in your life that may require you to reschedule your reserved appointment. If this occurs, we ask that you provide us with at list a 24 hours in advance notice. If you do not provide us with a 24 hour in advance notice or do not show up to your reserved appointment time, then the following fees will be applied to your account: (Please note that this is not a billable charge to your insurance.)
   1st – free
   2nd - $20.00
   3rd and so forth - $40.00

   (_____) *Please Initial*

2. Our relationship is with you, not your insurance company. Insurance will be filed, if we are a participating provider with your insurance carrier. You will need to prepare to pay the estimated amount for any deductible, co-insurance, and co-payment at the time services are rendered. You will be responsible for payment of any charges that are not covered by your insurance plan. After insurance is processed any unpaid portion will be invoiced to you for payment within 30 days. If you do not have insurance coverage, payment in full is due at the time services are rendered.

   (_____) *Please Initial*

3. **Finance Charge** - A finance charge will be imposed on each item of your account which has not been paid within ninety (90) days of the time the item was added to the account. The **Finance charge** will be computed at the rate an **Annual percentage rate** of ten (10%) percent.

   (_____) *Please Initial*

4. All FLMA, Disability forms, and Med pay forms will be charged $50.00 to be filled out. Other fees may apply based on the complexity of the forms.

   (_____) *Please Initial*

5. As Arkansas Internal Medicine Clinic P. A. we value you as a patient. In order to continue to provide exceptional service to all of our patients, timely payment of your account is crucial. If you fail to pay your account in full within 120 days following your office visit, we will refer your account to a collection agency and listed with the credit bureau. You shall be responsible for paying the fee that the collection agency charges for collection of your debt. The amount of that fee is 40% of our debt. That 40% will be added to your debt and collected by the collection agency. By initialing and signing below, you understand and agree to pay that fee. Also, please understand that you are still responsible for any court costs, attorney fees or recovery costs associated with collection of your debt.

   (_____) *Please Initial*

6. For all return checks, you will be responsible to pay for the check amount and any fees incurred with the return check. I understand that after one returned check the only acceptable payment method will be cash, credit card or money order.

   (_____) *Please Initial*

7. You grant permission to our office to telephone you at home, cell phone or at your workplace to discuss matters related to our account. Please give us the best method of contacting you.

   (_____) *Please Initial*

8. **MAKE SURE YOU RECEIVE A RECEIPT EVERYTIME YOU PAY TO PROVE PAYMENT.**

   (_____) *Please Initial*

9. Immigration patient's = we accept cash, cashier's check, credit card and check. If you have to pay by check, we will have to hold your final paperwork until your check has cleared the bank.

   (_____) *Please Initial*

I certify that I have read this form and that I hereby agree to abide by the conditions outlined herein.

_____ _____ _____

Print Patient Name **Date** **Patient Signature**