Financial Policy 2011

Patient Name______________________________ Date of Birth____/____/____

Junction City Medical Clinic is committed to making your experience at our clinic pleasant and professional.

Junction City Medical Clinic, as a courtesy, will submit your insurance claim, if proper information has been provided. If you fail to provide us with correct insurance information and your claim(s) is denied for "timely filing" you will be responsible for the balance. Co-pays are due at the time of your visit. If you do not know your co-pay amount; $25.00 will be required. If your co-pay is not paid at the time of your visit, you may be assessed a $10.00 non co-pay fee. If you do not have insurance, a deposit of $70 is due at the time of the visit. A 20% discount will be assessed on the office visit if paid in full the same day of the visit. We are happy to assist, but are not solely responsible to research why your insurance has not paid. If your account is turned over to a collection agency due to non-payment, a $50.00 administrative fee will be assessed.

There is a fee (currently $25.00) for any check returned by the bank.

Please cancel your appointment with a 24 hour notice. Patients that do not show up for an appointment will receive a letter for the first "no-show", may be assessed a $25.00 charge for your second "no-show", and may be discharged from the clinic after your third "no-show".

Assignment of insurance benefits: I understand that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay all costs and expenses including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment of medical benefits from my insurance company and/or Medicare directly to my physician. I understand some services provided might incur costs from outside laboratories and/or radiology providers. I have read, understand, and agree to the above financial policy for payment of professional fees.

Patient Signature:____________________________________Date______________

Guardian/Parent Signature:______________________________Date ______________