FINANCIAL POLICY

FINANCIAL RESPONSIBILITY AND INSURANCE BILLING

Family Healthcare of Fairfax, P.C. (FHF) participates with numerous health insurances and managed care plans, such as Medicare (Part B), Blue Cross/Blue Shield, and a number of other local and national plans. If your insurance plan is one FHF participates with, we are obligated by contract to collect any co-payments due before you check out of our office.

However, please be aware that some provided services may not be covered and not considered "reasonable and necessary" under a plan. It is the responsibility of the insurance member to know and understand the terms of his/her health insurance coverage. Further, FHF's participation status with health insurance plans is subject to change.

For insurance plans in which FHF does not participate, please understand that your insurance policy is a contract between you and your insurance carrier. FHF is not party to that contract and is not responsible for services considered "non-covered" or "not reasonable and necessary." By signing this document you acknowledge that if services are not covered by your insurance, you are responsible for payment. Payment for services should be made before checking out of the office. An encounter form will be provided to you for you to submit to your carrier with any required claim form. It is your responsibility to collect reimbursement under the terms and conditions of your health insurance plan.

RESPONSIBILITY FOR PAYMENT

In your capacity as patient or legal representative for the patient (guarantor), you are required to pay all charges for which you are legally responsible. Payment of fees is due at time of service upon receipt of the billing statement. Payment is accepted in cash, personal check, or credit card (MasterCard or Visa). There is a $25.00 charge for checks returned by the bank. Fees are subject to change.

If you have a dispute concerning a bill, please notify the Administrator, in writing, of the reason(s) of the dispute within 30 days of the billing date. Extenuating financial circumstances should be discussed with your physician at the time of service.

Collecting activity by FHF is costly, time consuming, and diverts attention from our goal of providing quality healthcare. Accordingly, in the event that timely payment on your balance is not made, your account may be referred to a collection agency. It is agreed that the patient/guarantor will pay all collection fees as well as all costs related to any legal action should such action become necessary.

RELEASE OF INFORMATION AUTHORIZATION

I authorize the release of necessary information, including medical information, regarding medical services rendered, to my insurance plan(s), including any managed care plan or other payer, Medicare, authorized private review entities acting on behalf of such insurance plans, the billing agents and collection agents or attorneys of FHF, or other parties for the purpose of satisfying charges billed and/or facility utilization review and/or otherwise complying with the obligations of state or federal law. A photocopy of the AUTHORIZATION may be honored. I understand that this authorization may be revoked by me at any time in writing to the Manager of FHF.

I further authorize FHF to submit claims for benefits on behalf of myself and/or dependents to my insurance carrier(s). I request that payment of authorized Medicare and all other health insurance benefits be made on my behalf to Family Healthcare of Fairfax, P.C., for any services rendered to me or my dependent(s).

The undersigned certifies that he/she has read this agreement, understands its terms, and is duly authorized to sign this form.

SIGNATURE: Patient (guardian/guarantor): _____ DATE: _____

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CONSENT FOR MINOR TO BE TREATED: _____Relation to patient: _____