Raleigh Family Practice
Financial Agreement

No-Shows
You must give our office 24 hours' advance notice of cancellation to avoid charges associated with missed appointments.
A no-show fee of $45 will be assessed if an appointment is missed with no notice or less than 24 hours notice. SculpSure and Laser No-shows will be charged the full amount of the scheduled procedure.

Forms
There will be a fee for forms and letters requested that are not related to an office visit. A fee in the amount $25-$100 may be charged and the Doctor/PA will make the determination of charging and how much.

Insurance Participation
We file claims for the following insurance companies: Aetna, BCBS and BCBS Medicare Plans, Cigna, Coventry, Humana Medicare PPO, MedCost, Medicaid, Medicare, State Health Plan, Tricare, United Healthcare and United Healthcare Medicare Plans. We are out-of-network with Humana Medicare PPO. (We do not file claims for Discount Cards and Workers' Compensation Claims.) We do not accept new patients on Medicare, Medicaid or Tricare, but we do accept Medicare for existing patients who age into it.

Third Party Payers
We do not file claims with third party payers for motor vehicle or other accidents. We will file your regular medical insurance if we participate and bill you according to insurance instructions if needed.

Eligibility Information
Our front desk staff will attempt to access eligibility and co-pay information prior to your arrival. We will also ask to verify your insurance and scan your insurance card. If you do not have current insurance information, you will be required to pay for the services rendered and file your claim to receive reimbursement.

Claims Filing
We will file claims for primary and secondary insurance plans with which we are contracted. We do not file with more than 2 insurers per claim. We accept the contractual write-off based on your primary insurance. Once we have received instruction from your insurance company, you will receive a bill for any outstanding balance. You will then be responsible for that balance.

Keep us informed
Most often errors in billing and claims payment are related to incorrect information. Please update us with name, address, phone number and insurance information as it changes.

Payment
We accept Checks, Cash, Visa/MC/Discover and Debit cards. All payments for service are due on the day the service is provided.

Co-Pays
Many plans require that a patient pay a co-pay at each visit. We are bound by our contracts with insurance companies to collect that co-pay at the time we render our services. In keeping with our contracts, we will collect your co-pay when you check in. If co-pay is not paid on the day your services are rendered, a fee of $10.00 will be added to your account. Patients with a history of not paying co-pays may be discharged from our practice, and we will notify the insurance carrier.

Patient Refunds
Refunds for overpaid services are issued by the 30th of each month.

Small Balances
You will not receive bills for balances less than $5. However, we will notify you on your next visit of the balance.

Returned Checks
We charge a $25 fee for returned checks. Patients who have written more than one returned check will be required to pay by cash. Multiple returned checks may result in discharge from the practice.

Billing Fee
We will add a $10.00 late fee each time we must send an additional statement for past due balances.

Delinquent Accounts
We will make attempts to contact you by phone and by mail regarding delinquent accounts. Failure to pay will result in accounts being turned over to Bull City Collection Agency. If your account is turned over, we will no longer offer medical care to the guarantor of the account or any family members for whom that guarantor is responsible.

Bankruptcy
Accounts written off due to bankruptcy will also result in termination from our practice. However, you may work with your Bankruptcy attorney to draft a letter expressing your intent to pay our bill and continue as a patient.

Charge for Medical Records
Medical records requested will be copied for the following fee: .75 per page 1-25, .50 per page 26-100, .25 all others, with a minimum fee of $10. Postage is also charged.

By signing below, I agree that I have read the above financial agreement. I understand and agree to adhere to the policies included within the agreement.

Patient/Guarantor Name: _____
Pt. /Guarantor Signature: _____
Date: _____ Chart # _____