

# Powhatan Family Physicians, Ltd.

## **OUR POLICY**

Thank you for choosing **Powhatan Family Physicians, Ltd.** as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Policies which we require you read and sign prior to any treatment. All patients must complete this information before seeing the doctor.

**PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE CO-PAYMENTS ARE DUE AT CHECK IN. WE ACCEPT CASH, CHECK, CREDIT CARD (VISA, MASTERCARD, AMERICAN EXPRESS) AND DEBIT CARD. ANY UNPAID ACCOUNT BALANCE OVER 61 DAYS IS SUBJECT TO A 1.5% INTEREST CHARGE.**

**Regarding Insurance** We may accept assignment of insurance benefits. However, we do require that all co-payments be made at time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information and an original insurance card at each visit to copy and keep on file. Your insurance company is a contract between you and your insurance company. We are not party to that contract. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance policies. You will be responsible for these balances.

**Adult and Minor Patients** Adult patients are responsible for full payment at time of service. The adult accompanying a minor and/or the parents (or guardians or the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized with VISA/MASTERCARD (which may be kept on file) or payment by cash or check at time of service has been verified.

**Returned Checks** There will be a \$25 returned check fee on all returned checks. In the event that a check is returned for insufficient funds, you will have only 14 days to pick by presenting cash, money order, or credit card to cover the amount of the check plus the \$25 fee. Any returned checks not picked up **will** be turned over to the attorney for collection.

**Collection Fees** In the event that your account is turned over to the collection attorney/agency, you will be responsible for all collection costs including interest and reasonable attorney's fees.

**Fees for Letters and Forms** Your physician will be more than happy to fill out any necessary form/s that you may need. Please be advised that due to the time required to dictate and complete letters and forms there will be a fee for this service. These costs are considered non-covered by insurance companies.

**Telephone and Fax Policies** Our policy is to avoid faxing medical records, however, in the event of an emergency situation, consent is made to share information with other providers for continuity of care. I give Powhatan Family Physicians, Ltd. permission to electronically transmit (fax) medical information & understand that they may not arrive at the intended location.

**DialTell** I give permission for PFP, Ltd to leave messages on the secure DialTell Service so I may retrieve my results of lab work or other tests.

**Legal (Deposition or Subpoena)** In the event any of our providers are deposed or requested to appear in court on your behalf, you will be responsible for all fees incurred, including but not limited to compensation for provider's time away from patient care, preparation for and review of your case, and copying your medical records. These fees are considered non-covered by insurance companies.

X \_\_\_\_\_  
Signature of Patient or Responsible Party

Date \_\_\_\_\_