Financial Policy

Dear Patient,

Thank you for choosing Columbus Integrative Family Medicine Center for your health care. We want to make your visits as easy as possible by providing information that will help you with our billing and payment procedures.

Be sure to bring these items with you to each visit:

- Valid Driver's License or State Issued ID
- Insurance Card(s)
- Payment such as cash, or credit card
- Test results, X-rays and any other materials, if asked to provide those

CIFMC has a 15 minute late policy. If you need to reschedule or cancel an appointment, contact our office at least 24 hours in advance. Phone numbers are provided below. If you miss an appointment without notice, a rescheduled appointment cannot be guaranteed. There will be a fee of $25 for all no shows and late cancellations. Repeated failure to keep your appointment may result in you being dismissed as a patient.

Payments

- At the time of your visit, you are responsible to pay any deductibles, copayment, coinsurance, or outstanding balance as specified by your insurance company.
- Any medical services not covered by your insurance company must be paid in full at the time of the visit unless you have made arrangements with us before the appointment.
- If you do not have insurance, you will be expected to pay full price of the visit (does not include the cost of labs and diagnostic tests) at the time of service unless other arrangements have been made with us
- You need to be sure that any needed referrals and authorizations for treatment are provided to us before the visit. Your visit may have to be rescheduled, or you may have to pay full amount for the services, if you do not provide the needed referral or authorization,
- Payments can be made with cash, check or credit card. Visa, MasterCard, American Express and Discover are accepted by our offices. There is a $30 fee for any check returned by the bank for any reason. If you have any questions or concerns, please contact our office at 614-515-5244.
- There is a fee for all disability, FMLA , Citizenship and other extensive medical forms.

Care of Children

- In the Event of a divorce, both parents will be considered equally responsible for payment. It will be up to the parent(s) to resolve divorce decree differences.

- With few exceptions, non-emergent treatment will be denied for any child unless the parent or guardian is present. If you cannot attend an appointment with your child, call the office in advance to see if arrangements can be made. Payment arrangements must be made prior to the appointment.

Insurance Benefits and Form

- Columbus Integrative Family Medicine Center contracts with many insurance companies. If you have insurance with one of these companies, our billing office will submit a claim for payment of services for you unless you instruct us not to. All needed insurance information, including special forms, must be completed by you before you leave your appointment.
- If Columbus Integrative Family Medicine Center does not contract with your insurance company, you will be responsible for any balance not paid by your insurance. While our billing offices will file a claim on your behalf to your insurance company, you may be required to pay Columbus Integrative Family Medicine Center before starting services. If payment is received from your insurance company after processing your claim, you will be refunded any extra amount after all changes have been covered.
- If you have questions about your specific insurance coverage, you need to call your insurance company. Their telephone number should be printed on your insurance card.
- Our staff is happy to help with insurance questions relating to how a claim was filed. We will also provide any additional information your insurance company might need to process your claim.
- It is the patients' responsibility to verify their benefits, network, states, deductible and co-pays.

I understand if I have an unpaid balance to CIFMC and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.

In order for CIFMC or their designated external collection agency to service my account , and where not prohibited by applicable law, I agree that CIFMC and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me , (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded /artificial voice message and/or use of an automatic dialing device, as applicable.

Financial Policy Acknowledgement

I have read or someone has read the form to me and I received my copy of the above Financial Policy. I agree to follow this policy.

_____ _____

Printed Patient or Responsible Party Name *Date*

_____ _____

Signature for Patient or Responsible Party *Date*

Columbus Integrative Family Medicine Center