

Financial Policy

Dear Patient,

Thank you for choosing Columbus Integrative Family Medicine Center for your health care needs. 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 every visit:

- Valid Driver's License or State Issued ID
- Insurance card(s)
- Form of payment (cash, card, and/or check)
- Test results, X-rays, updates list of medications, and current supplement bottles

CIFMC has a 10 minute late policy. If you need to reschedule or cancel an appointment, contact our office at least two business days in advance. If you miss an appointment without notice, a rescheduled appointment cannot be guaranteed. There will be a fee of \$50.00 for all no-show and late cancellations. Repeated failure to keep your appointment may result in you being dismissed as a patient.

Except where opted out below, you authorize CIFMC to send you appointment reminders via text/SMS or phone call (check appropriate box):

- Text/SMS appointment reminders and messaging
- Voice reminders and messaging

Payment

- At the time of your visit, you are responsible to pay any deductibles, co-payments, coinsurance, or outstanding balance as specified by your insurance company.
- Any medical services not covered by your insurance company must be paid in full by the time of the visit unless you have made arrangements with us before your appointment.
- If you do not have insurance, you will be expected to pay the full price of the visit (does not include the cost of lab work 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 your visit. Your visit may have to be rescheduled, or you may have to pay the full amount for the services, if you do not provided the needed referral or authorization.
- Payments can be made with cash, check, or credit card. We accept Visa, MasterCard, American Express, and Discover. There is a \$40.00 fee for any check returned by the bank for any reason.
- There is a \$50.00 fee for all disability, FMLA, citizenship, and other extensive medical forms.
- It is your responsibility to check with your insurance to make sure we are listed in- network. It is also your responsibility to check with your insurance regarding co-pays, deductibles for office visits, as well as, coverage of ordered lab work and tests.

Care of Minors

- In the event of a divorce, both parents will be considered equally responsible for payment. It will be up to the parents to resolve divorce decree differences.

- With few exceptions, non-emergency treatment will be denied to 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 Forms

- CIFMC 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 necessary insurance information, including special forms, must be completed by you before you leave your appointment.
- If CIFMC 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 CIFMC before starting your appointment. If payment is received from your insurance company after processing your claim, you will be refunded any extra amount after those charges have been covered.
- If you have any questions about specific insurance coverage, you need to call your insurance company. Their 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 may need to process your claim.
- It is your responsibility to verify 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 agency. I will be responsible for reimbursement of any fees for the collection agency, including all costs and expense incurred collecting my account, and possible reasonable attorney’s fees if so included 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 provided, 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 if an automatic dialing device, as applicable.

Financial Policy Acknowledgment

I have read (or someone has read to me) and understand the policy stated above.

Printed Name of Patient or Responsible Party

Date

Signature of Patient or Responsible Party

Date