



ADVANCED INTERNAL MEDICINE PRACTICE

AIM for better health

Financial Policy

Insurance:

- Patient understands that they are fully responsible for all charges. Our clinic will bill patient's insurance all services rendered. However, it is at the patient's insurance discretion to cover the charges incurred. If patient's insurance does not cover services, it is the patient's responsibility to dispute the charges directly with their insurance as it is a contract between the patient and insurance. If insurance declines payment claim, then patient is liable for all charges.

Patient Responsibility:

- Bring your insurance card to every office visit
- Copay and deductibles are due at the time of service, or if you do not have insurance be prepared to pay visit in full

Patient Financial Responsibility:

- \$35 fee for any checks returned for insufficient funds
- \$10 fee for printout of any ledgers (i.e., account history, payment history, etc.) fee is due prior to receiving the ledger.
- \$35 walk-in fee
- \$50 fee for FMLA or any medical form needing completion and signature.
- \$5 administrative fee for rushed requests on letters, forms, or any other documents.
- Monthly statements are billed and/or emailed out for balances, which are due within 14 days of the statements date. If you have disputes, concerns, or questions contact the billing department immediately.
- **\$35 fee for all missed/no show or if the appointment is not cancelled within 24-hour notice. At the third incident, a \$50 fee will be incurred, and the practice may choose to dismiss you as a patient.**
- Any prolonged service including record review, care team planning, and discussion with family will be billed to insurance and a copay or deductible may apply.
- If visit or procedure is aborted, if time and resources spent, appropriate claim will be submitted to insurance and patient will be responsible for copay or deductible.

I have read the above financial policy for Advanced Internal Medicine Practice, and I agree to the terms and conditions listed. I understand that I am financially responsible for ALL charges.

Print Name _____ Date _____

Signature _____