Vineville Internal Medicine

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Patient Financial Policy

To reduce misunderstandings between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager.

Unless other arrangements have been made in advance by either you or your health insurance carrier, all co-pays and deductibles are due at the time of the visit. Additional financial responsibility maybe determined after your insurance has processed your claim. For your convenience we accept Visa, MasterCard, Discover, American Express, Cash and Checks. Checks returned for NSF will incur a $25.00 fee which will be added to your account balance.

Patient Insurance

We have made prior arrangements with many insurers and health plans to accept assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. Our office policy is to collect this co-payment when you arrive for your appointment.

If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of the service.

In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

Minor Patients

For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

All patients under the age of 18 will not be seen without a parent or guardian present/or without a signed consent form.

Self Pay Patients

For all services rendered to patients without insurance or proper proof of insurance a self pay charge will be applied to your account. Payment is due at the time of services rendered unless previous arrangements have been made with the billing office. Any test performed that may result out abnormal causing other test to be performed will be charged to your account.

Patient Agreement:

I have read and fully understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

Patient Name Printed: _____ DOB: ___/___/_____

Patient/Responsible Party Signature: _____

Date: ___/___/____

CC: _____ (account#)