

**WESTERN WASHINGTON MEDICAL GROUP  
DEPT OF FAMILY MEDICINE AND PEDIATRICS**

**OFFICE/FINANCIAL AGREEMENT**

Patients must give WWMG Dept of FM **24 hours** notice for any cancellation. We frequently have patients waiting for an appointment to open up.

We consider all patients as “**private**” unless their insurance is one whom with we have a contractual agreement. We will bill your insurance as a courtesy but the balance for “**private**” patients is due and payable within 30 days. Many insurance plans cover a certain percentage only of the fees charged. The insurance normally only covers the “usual and customary” fees. Your insurance, as a result, may cover less than you thought they might or you may have a deductible to meet first. You may have scheduled a visit that is not covered by your insurance, such as Preventative Care, it is the patient’s responsibility to check their benefits prior to being seen.

\*Please be familiar with the benefits provided by you’re your health plan.

If your insurance requires a referral or if we need insurance authorization prior to your visit, it is **YOUR** responsibility to see that your health plan requirements are met. If you’re insurance information or other documents needed are not provided at or prior to your first visit, any charges incurred will be your responsibility.

If there is no insurance coverage we ask the patients to pay a deposit of **\$131.00** if they are new and **\$77.00** if they are an established patient at the time of service.

Then we will bill then accordingly for any balances due.

**Co-pays are due at time of service**, if you are unable to pay your co-pay at time of service there will be an **additional \$15.00 fee** charged to your account.

Should the account be referred over to our collection agency the undersigned, or their agent, will be responsible for payments of interest on the unpaid balance of 1% per month from the date of the service, collection fees, reasonable attorney fees and court costs.

We charge **\$35.00** for any NSF checks. ( per RCW 62A-3-515 & 520 )

With my signature, I acknowledge that I have read the above statement and agree to pay any charges within 30 days of receipt of statement unless other arrangements (such as contractual insurance) have been made. I authorize the physician to release my information required to process my insurance claims and authorize my insurance company to make payment directly to my physician.

**I HAVE READ THE FINANCIAL AGREEMENT. I UNDERSTAND AND AGREE TO THIS POLICY.**

**Signature :** \_\_\_\_\_

**Date:** \_\_\_\_\_

This signature is good for one year form the original date signed.