

WESTERN WASHINGTON MEDICAL GROUP DEPARTMENT OF SURGERY

FINANCIAL POLICY

Thank you for choosing WWMG Department of Surgery to meet your specialized medical needs. We are committed to providing you with the best treatment available. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, of which we require that you read and sign.

All new patients must complete our Patient Registration Form as well as our Financial Policy prior to seeing the physician.

PAYMENT IN FULL MAY BE REQUIRED AT THE TIME OF SERVICE

PATIENT'S WITH NO INSURANCE WILL REQUIRE A \$200.00 DEPOSIT FOR THE VISIT

**FOR YOUR CONVENIENCE WE ACCEPT CASH, CHECKS, VISA, MASTERCARD
AND AMERICAN EXPRESS**

PAYMENT PLANS ARE ACCEPTED UPON APPROVAL

REGARDING INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will bill your insurance plan for you, as long as you provide us with the correct information. Please be aware that some, and perhaps all, of the services provided may be non-covered services and/or not considered medically necessary under your health insurance plan. You, as the patient, ultimately are responsible for payment of all services provided by our Care Center. While payment is your responsibility, we will assist you in negotiating a settlement with your insurance company for any disputed claim. Our Patient Accounts department is available to discuss any questions you may have regarding your insurance or your account at 425-339-8584.

Regarding insurance plans where we are a participating or preferred provider, all co pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating or preferred providers refer to the above paragraph.

If you have a secondary insurance, we will bill it one time only for you, as a courtesy, as long as you have provided us with the appropriate information.

If you bill any insurance yourself, please do so promptly, so that you will receive reimbursement before your account is considered delinquent.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MEDICALLY NECESSARY CARE: We will only provide you with a service if we consider it medically necessary. Therefore if your insurance company arbitrarily determines that a service we have rendered to you is unnecessary, you will be responsible for the bill.

REFERRALS: It is your responsibility to obtain the appropriate referral from your primary care physician. We will assist you with this if necessary; however, your appointment may have to be rescheduled if the appropriate referrals are not in place on the date of your appointment.

CREDIT POLICY: Accounts are due and payable as of the date billed. Unpaid balances will be considered delinquent after 60 days.

We realize it may be necessary on occasion to arrange installment or other payment programs. If financial problems arise, please contact our Patient Accounts department as soon as possible by calling 425-339-8584.

If an account becomes past due with no valid reason, necessary action will be taken to recover the account balance due.

RETURNED CHECKS: Any returned checks will be assessed at a charge of \$35.00. The only exception to this policy is if you bring in cash within 24 hours of being notified by our office that we have received your check back as unpaid.

CREDIT BALANCES: It is the policy of this office to routinely refund any balance \$5.00 and over. If you are aware that you have a credit balance that is less than \$5.00, we will gladly refund the amount back to you if you call and notify us.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X _____ Appt. Date: _____
Signature of Patient or Responsible Party

_____ Account # _____
Please PRINT Name