WESTERN WASHINGTON MEDICAL GROUP
FAMILY MEDICINE

OFFICE/FINANCIAL AGREEMENT

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, <u>it is **YOUR** responsibility to see that your health plan requirements are met</u>. 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.

<u>If there is no insurance coverage</u> we offer our patients a <u>**30%**</u> discount when <u>they pay at time of service</u> or we will require them to pay a deposit and we will set them up on a monthly payment plan.

<u>**Co-pays are due at time of service**</u>, 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, may be responsible for payments of interest on the unpaid balance of 9% per month from the date of the service, collection fees, reasonable attorney fees and court costs.

We charge <u>**$35.00**</u> 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.

Printed Name____ **DOB:** __________________

Signature :____________________________________ **Date:** __________________