ADVANCED FAMILY MEDICINE
Your family's home for health

ADVANCED FAMILY MEDICINE FINANCIAL POLICIES

This is an agreement between Advanced Family Medicine and the patient or responsible party of the patient. Please review this document carefully. By signing this document, you are acknowledging that you understand and agree to our financial payment policies as well as any office policies as outlined.

Advanced Family Medicine participates with many health insurance plans. Refer to your carrier's website or contact their customer service department to verify our participation. Your insurance policy is a contract between you and the insurance company. It is your responsibility to know your insurance policy benefits and be familiar with your coverage. You will be responsible for any service that may be considered "**not covered**" by your insurance company. In addition, you are responsible for all unpaid balances.

Advanced Family Medicine will bill your primary insurance as a courtesy and make every effort to ensure claims are promptly and correctly submitted. Billing processes are handled through **OnDemand Billing Solutions**: 208-947-5390 and you may contact them if you are experiencing insurance difficulties, need payment arrangements or have any claims questions.

Payment is DUE at time of service: AFM accepts cash, personal checks, Visa, Mastercard, Discover and debit cards

Payment is due in full at the time of service for copays, coinsurance, deductible balances, and for patients without insurance. You may be asked for a current insurance card and billing information at each visit. You may be asked to have your photo taken for patient recognition and/or a copy of a photo ID in an effort to reduce insurance fraud.

Self-Pay: For patients without health insurance, payment is due at the time of service but is eligible for a 15% discount, provided that no claim is submitted to any insurance company for reimbursement. Subsequent visits may be eligible for a payment plan. Plans require 50% of the total due and payable at the time of service and any balance remaining paid within 60 days.

Credit and Finance Charge Policy: I understand that I am financially responsible for all charges regardless of third party involvement. I agree to pay the deductible, co-insurance, co-pay, or any service(s) deemed a "non-covered benefit" or "experimental" by my insurance carrier at the time service was rendered. I understand that failure to pay outstanding balances within 60 days of notification of the amount due may result in submission to an outside collection service. If your account is sent to an outside collection service (CBI-Collection Bureau of Idaho) it may result in interest accruing and have a negative impact on your credit. In addition, you and any family members may be discharged from the Practice.

Returned Checks/NSF: A return check fee of $25.00 or the maximum allowed by law, will be assessed to your account for all NSF checks.

Assignment of Benefits: You request that payment of authorized Medicare, commercial insurance, or third party benefits made on your behalf be paid directly to Advanced Family Medicine for any services furnished to you by any Advanced Family Medicine healthcare professional. This includes secondary, tertiary, and gap policies. You authorize the holder of your medical information release to the Health Care Financing Administration and its agents any information needed to determine the assignment of these benefits or the benefits payable for related service.

I hereby authorize AFM to furnish insured's insurance company all information (including but not limited to HIV, Sexually transmitted diseases, drug/alcohol abuse, mental illness, or psychiatric treatment) which may be requested by them concerning my illness or injury. I also authorize the release of information regarding work related injuries to my employer.

By signing this document, I recognize and acknowledge that I am completely responsible for all charges that I may incur at Advanced Family Medicine. I certify that all of the information provided is current and accurate.

Signature of Patient or Responsible Party: _____ **Date:** _____