Financial Policy

Patient Name: _____ Date of Birth: _____

Thank you for choosing Tri-County Medical Associates, Inc. (TCMA) as your healthcare provider. We are all concerned about the rising cost of health care and we are committed to providing you and your family with the highest quality and affordable health care. The following is a summary of our financial policy.

1. **Insurance**. We participate in most insurance plans, including Medicare. We must obtain a copy of your current card in order to bill on your behalf. If you fail to provide us with correct insurance information you will be responsible for your bill. It is your responsibility to know your benefits. Please contact your insurance company directly with any questions you may have regarding your coverage.
2. **Co-payment, Co-insurance and Deductibles**. All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Additionally you may be responsible for deductibles and co-insurance which is to be paid upon receipt of our statement. The person accompanying the patient is responsible for all co-payments or other money due at the time of service.
3. **Prompt Pay Discount**. TCMA will reduce the total charge of services provided by 30% (thirty percent) when a patient pays for the service within 30 (thirty) days. Co-payments, supplies and drugs are excluded from the discount.
4. **Non-payment**. If your account is past due, we may refer your account to a collection agency and you may be discharged from this practice
5. **Uninsured Patients.** Patients without insurance are expected to pay for the service at the time of service.
6. **Referrals and Authorizations.** If your insurance company requires a referral from your Primary Care Physician (PCP), it is your responsibility to obtain the referral. It is also your responsibility to verify that your PCP is listed correctly with your insurance company. If the PCP is not correct at the time of service, you will be responsible to pay for the services rendered.
7. **Non-covered Services**. Please be aware that some of the services you receive may not be covered by your insurance. If you and your provider agree non-covered services are needed to provide you with the highest level of care, payment in full for these services may be expected at the time the service is rendered.
8. **Returned Checks.** Checks returned by the bank will be assessed a $30.00 processing fee. These charges will be your responsibility and billed directly to you. Repeated returned checks will result in acceptance of cash only at the time of all future visits.
9. **Missed Appointments**. Our policy is to charge for appointments not cancelled at least 24 hours prior to the scheduled appointment. The charges will be your responsibility. Multiple missed appointments may result in being discharged from Tri-County Medical Associates, Inc. Please help us to serve you better by keeping your scheduled appointment.

It is our privilege to provide quality health care to our patients. Please let us know if you have any questions or concerns about our financial policy.

I have read and understand the financial policy and agree to abide by its guidelines. I further authorize Tri-County Medical Associates, Inc. (TCMA) and their business associates and assignees to contact me for any purpose related to my health care, including but not limited to, the collection of my accounts or other financial issues and reminders about my prescription refills and appointments. (1) By telephone at any number associated with me, including wireless numbers and to use pre-recorded/artificial voice messages and/or an automatic dialing device (ATDS). (2) Via answering machine, voicemail message, text message or email.

_____ _____

Signature of Patient or Responsible Party **Date**

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Relationship to Patient

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