Great Lakes
Medical Associates

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Financial Policy
Patient Financial Agreement

Great Lakes Medical Associates, PC. is committed to serving our patients with professionalism and caring and from our patients we expect the same commitment. This includes arriving on time for your appointment and calling to cancel if you are unable to keep your appointment. It also includes financial responsibility, such as presenting your identification and insurance cards at every appointment and paying your copay and deductible at the time of your office visit with cash, check or credit card.

Your responsibility is to provide us with accurate and complete information concerning your primary and secondary insurance medical benefits, including referral documents from other providers. Current identification and insurance benefit cards are to be presented at each office visit. As a courtesy, Great Lakes Medical Associates will file your insurance claim for you. If you are a Medicare patient, we will bill Medicare and your secondary insurance for you.

For services provided outside of our clinic, such as radiology, laboratory, surgery centers, physical therapy, hospitals and rehabilitation centers, it is your responsibility to know which facility you are required to use. If you have questions regarding coverage of these services, please speak with your insurance member services or one of our staff members before scheduling.

Patient Financial Responsibility Contract

Please read & initial each blank and sign where indicated – this document describes your financial responsibilities.

This is a legally binding contract between Great Lakes Medical Associates, PC and you. The words, *I, me, my, you and your* all refer to the patient.

_____ (initial) I agree to be financially responsible for payment of Great Lakes Medical Associates, PC's services. Cash, check or credit cards are acceptable forms of payment for these services.

_____ (initial) Current insurance cards must be presented at every office visit. Great Lakes Medical Associates, PC is not responsible for filing your insurance claim, but as a courtesy we will do so. I agree to pay the remaining balance after my insurance has paid on my claim immediately upon receipt of a statement.

_____ (initial) I agree to give Great Lakes Medical Associates my complete and accurate insurance information for primary and secondary insurance benefits including referral documents from other providers, if needed. I understand that if I fail to give complete and accurate information about my insurance benefits this may result in a denial of my claim or a delay in payment. I agree to pay Great Lakes Medical Associates, PC the balance on my account after my insurance claim has been processed.

_____ (initial) I understand that I will be responsible for any missed or cancelled appointments in which a 24-hour notice was not given. There will be a fee of $50.00 for any missed office visits and $75.00 for any missed office ' procedures.

_____ (initial) I understand there will be a $35.00 fee for all returned Checks

_____ (initial) I understand that my benefits may not cover all services or might deny payment for services that have been approved of in advance. I agree to pay the balance remaining on my account after insurance has been processed.

_____ (initial) If I do not currently have insurance benefits, I agree to pay $150 for my Initial New Patient visit & $100 for my office visit in advance and understand that other charges, for additional services which my provider finds medically necessary, may apply.

_____ (initial) Great Lakes Medical Associates, PC has a contract with my insurance company. Great Lakes Medical Associates, PC will receive payments from my insurance company for ***covered*** services provided by my insurance benefits. I agree to pay co-payments and deductibles at the time of service. If co-payments are not made at the time of service, I understand that my appointment will be rescheduled.

_____ (initial) I agree to pay any balance remaining on my account for any reason upon receipt of a statement and I understand that when requested, I must give Great Lakes Medical Associates, PC my current address and other contact information. I understand that if I fail to pay the balance on my account this may result in Great Lakes Medical Associates, PC pursuing any collection means possible.

_____ (initial) If my account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, I will be responsible for a fee of $25.00 to cover collection costs incurred by the office.

_____ (initial) If the reason for my appointment is related to a work injury or auto accident, I agree to give Great Lakes Medical Associates, PC the case or policy number, the workman's compensation or insurance carrier's name, address or other contact information at the time of my appointment so that Great Lakes Medical Associates, PC can bill workman's compensation or the auto insurance carrier for my visit. If I do not provide this information at the time of the visit, I agree to pay all charges for my visit.

I have read and I understand Great Lakes Medical Associates, PC's financial policies and I accept responsibility for the payment of any fees associated with my care.

_____ _____

Patient Signature **Date**

_____ _____

Witness Signature **Date**