OAK MILL MEDICAL ASSOCIATES
FINANCIAL PAYMENT POLICY

The purpose of this form allows Oak Mill Medical Associates to treat you, bill any insurance you may have, and to collect your account.

EFFECTIVE MAY 1, 2008

We, at Oak Mill Medical Associates, are committed to providing quality healthcare at the most reasonable cost to you. Effective May 1, 2008, we will be instituting the following policy changes to our practice.

1. NO SHOW POLICY:

When you do not call to cancel your appointment, time reserved especially for you, often goes unfilled. This deprives other patient's time to be seen, as well as, increasing the cost of providing health care through loss of revenue. If you do not cancel your appointment within 24 hours prior, you will be assessed a fee based on the time slotted for your appointment. An uncancelled physical/annual slot will result in a charge of $75.00. An uncancelled follow up or routine appointment will result in a charge of $40.00. Please be advised that your insurance will not cover this fee. Please note, as of October 1, 2007, we are legally able to adhere to this NO SHOW policy.

2. INSURANCE:

We participate with Medicare and many other insurance companies. If your insurance is an insurance we are contracted with, we will bill your insurance company along the guidelines of our contract. However, co-payments, co-insurances, deductibles, and non-covered services that have not been satisfied, are the responsibility of the patient and payment is expected at the time services are rendered. If you have an insurance plan that we do not participate in, you will be required to make payment at the time the services are rendered. You will need to submit a copy of the bill to your insurance company that we do not participate in for your insurance company to reimburse you directly.

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3. COLLECTION FEES:

We have employed a collection agency to handle delinquent patient accounts. Patients will be charged –

- $35.00 for Phase I
- $35.00 for Phase II

In the unfortunate event that this occurs, these additional fees will be the patient's responsibility. If you are unable to pay your bill please contact our billing department for a payment plan. Failure to make a payment within 90 days from being placed in collections will result in dismissal from the practice.

4. ADDITIONAL FEES:

- CO-PAYS ARE DUE IN FULL ON DATE OF SERVICE.
- THE FEE FOR A RETURNED CHECKIS $25.00
- A $5.00-$30.00 FEE WILL BE CHARGED PER FORM-EX.HANDICAP PLATE FORM - $5.00, DISABILITY AND FMLA - $10.00 PER PAGE.
- CHANGES OR CORRECTIONS WITH INSURANCE INFORMATION SUBMITTED TO US PAST THE TIMELY FILING DATE WILL BE YOUR FULL FINANCIAL RESPONSIBILITY.
- REGISTRATION FORMS NEED TO BE UPDATED WITH SIGNATURES ANNUALLY.

I have read the above and agree to the terms:

______________________________	______________________________
Patient or Guardian Signature (Must be 18 or older to sign)	Date
Please print patient name	Patient Social Security Number
Please print Guardian's name	Guardian's Social Security Number

Please have your insurance card(s) and a photo ID ready for the receptionist to copy.

Thank you!

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