Family Care Clinic of Western Kansas, LLC
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Thank you for choosing us as your health care provider. We are committed to your successful treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to treatment. For your convenience, we accept cash, checks, most major credit/debit cards, and Care Credit as sources of payment.

RESPONSIBILITY STATEMENT
Your insurance is a method for you to receive reimbursement for fees you have paid the physician for services rendered. Having insurance is not a substitute for payment. Charges incurred for services rendered are the patient's responsibility regardless of insurance coverage. Your insurance coverage is a contract between you and your insurance company, not your insurance company and our office. Many companies have fixed allowances or percentages based on your contract with them, not our office.

It is your responsibility to provide us with accurate insurance information and to inform us of any changes in your coverage as they occur. You are responsible for all copays, coinsurance, deductibles, and non-covered services/items. We will assist you in receiving reimbursement, but you are responsible for your bill. You are also responsible for knowing your insurance policy and plan. Billing your insurance is a courtesy we extend to you and this courtesy may be revoked if we are not kept up to date with your insurance information.

If your check is returned unpaid, the state's maximum allowable service fee will be automatically added to your balance. In addition, if your check is returned to us, you will need to make payment by cash, money order, or credit card for the balance due and the service charge. Please be advised that you may be placed on a "cash only" basis and we may not accept future checks from you.

If your check is returned to us for any reason, we reserve the right to put you on a "cash only" basis and no longer accept checks from you.

Please understand that we cannot waive deductibles, coinsurances, or copays that are required by your insurance. This is a violation of our contracts with the insurance plans. These contracts us obligate us to collect the copay at the time if your visit, even if you are sick. If you receive two different types of services on the same day, you will be asked to pay two copay amounts if required by your insurance plan.

If you fail to pay your bill in a timely fashion and your account is sent to an outside company or firm for collections action(s), any fees charged by that company or firm will be added to the amount you owe. Your family will also be terminated from care at our clinic.

PAYMENT AGREEMENT FOR OBSTETRICAL CARE
You will be given an *estimate* of the fees for these services, based on the physician's fee schedule, what your deductible, co-insurance is and at what percentage your insurance company covers for such services. You will be expected to pay, in full, for the amount that will not be covered by your insurance on or before your 36th week of pregnancy.

We take cash, check, and credit card payments.

PRIOR AUTHORIZATION AND REFERRAL REQUIREMENTS

You must obtain any necessary prior authorizations and/or referrals required by your insurance company, prior to your scheduled appointments.

NON-COVERED SERVICES
Please be aware some, and perhaps all, of the services to be rendered are not considered reasonable and necessary under Medicare, Medicaid, or other medical insurances. You will be responsible for these balances. We check insurance eligibility and benefits electronically at each visit. If a service is non-covered, you will be asked to pay on the day of the appointment for that service.

MISSED APPOINTMENTS
Due to excessive late cancellations and no-shows, our policy is to charge **$100.00** for missed appointments or late cancellations at our discretion. This fee is not covered by insurance and will not be billed to insurance. You will be expected to pay this in full prior to being seen at your next appointment. Failure to show up for your appointment at the assigned time inconveniences all parties involved. **Excessive cancellations or no-shows may result in you being dismissed from the practice.** Please help us serve you better by keeping your appointments.
I have read the Financial Policy. I understand and agree to comply with this Financial Policy.

_____	_____	_____	_____
Guarantor's Printed Name	*Guarantor Signature*	*Patient Name & Date of Birth*	*Date*