



### FINANCIAL POLICY

Thank you for choosing Quality of Life Medical Center for your healthcare needs. We are committed to providing you with the best possible care. Your clear understanding of our financial policy is important to our professional relationship.

You will be asked to provide your personal identification and proof of insurance for verification at check in for each office visit. It is your responsibility to make sure we have your correct personal and insurance information.

**PAYMENTS:** Co-pays are due at the time of service and are payable by cash, check, debit or credit card. Any previous balance needs to be addressed prior to seeing the Physician, unless other arrangements have been made with the office manager.

**INSURANCE:** We will submit claims to "primary" insurance plans according to the terms of the individual agreements with the insurance company when they exist. We will also bill secondary insurance as a courtesy to our patients. However, if payment is not made by the secondary insurance within 60 days of submission, you will be responsible for any balances due.

Please note you will be responsible for non-covered services per your insurance contract.

**SELF-PAY:** Self-pay patients must pay on the date of services unless prior arrangements have been made.

**ADDITIONAL FEES:** Quality of Life Medical Center charges a \$35.00 non-sufficient fund fee on all returned checks. This practice also reserves the rights to charge a 30% processing fee to any delinquent account referred to collections.

**CANCELLATIONS:** We want to make sure our patients have access to their doctors when they need them. To help keep our doctors on time, please give our office at least 24 hours advance notice when you need to change or cancel an appointment. Otherwise, a \$25 cancellation or no show fee may be charged. Repeatedly not showing up for appointments will lead to dismissal from the practice.

**I have read and understand the financial policy of Quality of Life Medical Center. I understand that I am personally responsible and liable for payment of any balance on my account.**

Patient/Responsible Party – Printed Name \_\_\_\_\_

Patient/Responsible Party – Signature \_\_\_\_\_

Date \_\_\_\_\_