8

North Phoenix Internal Medicine P.C.
(Effective December 1, 2002)

Thank you for choosing North Phoenix Internal Medicine P.C. as your Primary Physician. We welcome you! We are committed to providing the finest in personalized and professional health care possible for our patients. Please carefully read and sign the following statement policy prior to treatment. Feel free to speak to our office personnel if you have any questions.

The patient of their guarantor is responsible for payment of services that are rendered. If we are a preferred provider on your insurance plan, we will submit the claims to your insurance company and make every attempt to collect with the information that you provide. Please present you insurance card at each visit. You will be responsible for all co-pay, coinsurance, and deductibles on the day of service. Should an overpayment occur on the deductible or percentage amounts charged we would apply a credit to your account. A refund is available upon request.

IT IS YOUR RESPONSIBILTY TO BE AWARE OF YOUR INSURANCE BENEFITS.

You are ultimately responsible for payment of services rendered if your insurance carrier does not pay for any reason. If we do not receive payment within 60 days, the patient will be billed. If you are unclear of your insurance benefits, you will need to contact your insurance carrier for clarification of coverage. If you are waiting for coverage to become effective if you do not have insurance, payment in full will be expected the day you are seen. For your convience, we accept VISA, MasterCard, cash, or checks.

Delinquent accounts over 90 days will be subject to the following action. Your outstanding balance will be turned over to J.R. Brothers Financial Inc. for further processing.

There will be a $25 service fee for all returned checks. NSF checks must be redeemed with certificed funds. (Cashier's check, money order, certified check or cash)

If you need to cancel a scheduled appointment, please contact our office at least **24 hours** before your appointment time. Because of high demand for appointments, missed appointments prevent us from scheduling appropriately and to care for others in need of urgent care. **A $50 FEE WILL BE ASSESED FOR ALL MISSED APPOINTMENTS NOT CANCELLED WITH AT LEAST 24-HOUR ADVANCE NOTICE.**

It is your responsibility to notify our office if there is a change in your insurance coverage, residence, or phone number.

I have read and I understand the above Financial Policy and I agree to abide by its terms.

PRINTED NAME OF PATIENT _____ SIGNATURE OF PATIENT/RESPONSIBLE PERSON _____

DATE: _____