Centennial Primary Care
Financial Policy

Thank you for choosing Centennial Primary Care for your Medical Home. We are committed to providing the best healthcare possible. The following explains our Financial Policy, which we ask you to read carefully, initial where indicated and sign below.

- All patients are required to provide accurate and complete Personal and Insurance information prior to being seen, including Social Security Number and a picture I.D.
- We accept cash and checks, as well as Visa, Mastercard and Discover cards.

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Co-payment, Co-insurance, Deductibles as well as any previous balance owed, are due at time of service. If you are unable to pay your portion, we ask that you reschedule your appointment or make prior financial arrangements.

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We are considered in-network with most PPO's, however; it is <u>your</u> responsibility to ensure that we are on your particular plan.

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If we do not participate with your insurance plan, or if you are Self Pay, you will be required to pay in full at the time of service. We do offer substantial discounts for payment in full. Please note that if you are unable to pay in full at the time of service, you will not be eligible to receive our discounts.

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In-office procedures such as biopsies, wart freezing, ear washes etc. may fall under your deductible. Tests ordered by our office that are performed off-site including X-rays, CT scans, MRI's, Ultrasounds and some Labwork are typically applied to your deductible. Every patient's insurance plan is different, thus we do not know your benefits for some services. Please contact your insurance company for detailed information BEFORE having a test performed, if you have a question.

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Returned checks will be subject to a $30.00 fee. If we receive a returned check, we will not be able to accept checks from you in the future; cash or credit card will only be accepted.

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We will file claims to your insurance company (or companies); however, **<u>if your insurance company denies payment or holds your claim past 60 days for any reason, you will be responsible and will be billed for any balance.</u>**

I have read the above Financial Policy and I understand and agree to the terms therein.

X_____ X_____

Signature of Patient or Representative **Date**