Oakwood Family Care

Patient Billing Policy

You are Responsible for:

The providers of Oakwood Family Care are here to serve your healthcare needs and are dedicated to providing to you the best care possible. The intent of this billing policy is to clarify the role of the patient and the providers regarding billing issues. We ask you too **carefully** read and sign the following Financial Policy. Our relationship is with you the patient not your insurance carrier.

YOU ARE RESPONSIBLE FOR:

- Knowing what services are covered by your insurance carrier
- Knowing that Oakwood Family Care cannot honor a request to alter or change information on an insurance claim in order for the claim to be processed or paid
- Knowing that you are **ultimately** responsible for all charges
- Presenting your insurance card(s) to the receptionist at every visit
- The payment for services rendered to dependent children

PAYING YOUR BILL:

- If you do not have insurance you must pay at the time of service. We will reduce the charge so it is in line with allowable amounts paid by other insurance companies.
- If you do not receive an Explanation of Benefits within 45 days, please contact your carrier
- Oakwood Family Care bills your insurance as a courtesy
- The following payments are due at the time of service, **Co-payments, deductibles, charges for non-covered services, and outstanding debts.**
- Oakwood Family Care accepts: **Cash, Checks, Major Credit Cards and Debit Cards**

FAILURE TO PAY YOUR BILL MAY RESULT IN:

- $25.00 service charge on all returned checks
- Your account being turned over to collections to our outside collection agency
- A bad credit rating

Oakwood Family Care agrees to work with each patient to resolve outstanding balances.

By signing below I fully understand Oakwood Family Care payment and billing policy, I also hereby authorize Oakwood Family Care to furnish information to my insurance carrier(s) concerning illness and treatment in order for reimbursements. I understand that in the event that my insurance does not pay for any reason that it is my responsibility to pay any up paid balances.

In the event that the patient is a minor, I am the parent and/or legal guardian of said patient and I agree that I am responsible for all services rendered to the patient.

_____ _____

Patient/Parent/Guardian Signature Date

_____

Patient/Parent/Guardian Printed Name

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Printed Name of Patient (if minor)