FINANCIAL POLICY

____ ____________________
Patient Name Date of Birth

Thank you for choosing Crossroads Medical Group, PLLC for your medical care. Our goal is to be a "state of the art" medical practice. You can help us achieve that goal by understanding our billing policy.

We participate with most of the insurance plans in the area. We will gladly file a claim to your insurance company. Insurance is filed as a courtesy to our patients. Please make sure we have a copy of your most recent insurance card. If we do not have correct insurance information on the date of service and your claim is denied, you are responsible for payment if your insurance company denies the claim. It is your responsibility to verify if our office is in network for your plan.

It is our policy to collect all co-pay and deductible amounts at the time of service. These amounts are approximate and based on what your insurance carrier usually pays. There may be a balance after insurance which will be billed to you after your insurance carrier processes your claim. Prompt payment of your balance after insurance is expected within 30 days of billing.

If you schedule an appointment with our office and you cannot keep your scheduled appointment, you must give a 24 hour notice or you will be charged a **$20.00 No Show Fee**.

If you do not have health insurance coverage, full payment is expected at the time of service. We offer a self-pay discount if you pay in full on the date of service. It is up to our office manager or practice administrator to decide if they will see you without payment in full on the date of service. Payment of balance is expected within 30 days of billing.

For your convenience, we accept payment by cash, check, VISA or MasterCard. If you have questions about your bill, please contact us and we will help you resolve any problems.

FINANCIAL AGREEMENT

I understand that I am financially responsible for all charges, even if they are not covered by insurance. If my insurance does not pay within 30 days, I understand that I am responsible for those charges. In the event that I do not pay in accordance to the above policy and my account becomes 90 days past due a 30% collections fee will be added to my account balance, I agree to pay all costs of collection, including attorney fees. I authorize the release of medical information or records as necessary in order for Crossroads Medical Group, PLLC to collect payment. I hereby assign payment to Crossroads Medical Group, PLLC.

____ __________________
Signature of Financially Responsible Party Date

____ ____
Printed Name of Financially Responsible Party Relationship to Patient

____ ____
Social Security Number for Responsible Party Date of Birth for Responsible Party

CONSENT TO TREAT

I, _____________________________________ hereby authorize Crossroads Medical Group, PLLC and any of its physicians and/or staff to treat my medical condition(s). The risks, benefits and alternatives will be explained at the time of service. I have the right to question and/or refuse treatment. I hereby release Crossroads Medical Group, PLLC and its physicians and/or staff from any liability.

Responsible Party Signature: ____Date:_________________

Relationship to patient____