

# **Ashburn Family Healthcare, PLLC**

## **POLICY REGARDING PAYMENT OF SERVICES**

Thank you for choosing us as your Primary Care Provider. We are committed to providing you with quality and affordable health care. We have developed this payment policy to help our patients understand patient and insurance responsibility for services rendered in our office. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

**1. Insurance.** We participate with several insurance plans and networks, including Medicare. In order to be seen, you must provide us a copy of current valid insurance card and your driver's license. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.**

**2. Co-payments and Deductibles.** All co-payments, deductibles and co-insurances must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

**3. Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. **Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.**

**4. Non-covered services.** Please be aware that some - and perhaps all - of the services you receive may not be covered or may not be considered reasonable or necessary by your insurance. You must pay for these services in full at the time of visit. Please see separate document for some examples of non-covered services.

**5. Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

**6. Nonpayment.** We expect you to pay your account balances promptly. Please understand that the reason you will have an account balance is because we provided services to you when you needed them the most without collecting the money upfront. It is your responsibility to pay your balance so we can continue to provide the excellent quality services to you and all our patients. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy.

I have read and understand the payment policy and agree to abide by its guidelines:

\_\_\_\_\_  
**Signature of Responsible Party**

\_\_\_\_\_  
**Patient's Name**

\_\_\_\_\_  
**Date**