Holvik Family Health Center

Financial Waiver

Insurance: Always have your insurance card with you for all visits. If we ask for a current copy of your insurance card, and you do not have it, then you will be asked to reschedule.
a. It is the patient's responsibility to verify change of PCP prior to your appointment (for all HMO insurances).
b. It is the patient's responsibility to update any new insurance information in order for us to properly bill your insurance carrier.
c. We DO NOT do any third party billing or treat Workman's Comp.
d. We are not accepting new Medi-Cal or cash accounts.
e. As a courtesy, our office will bill your insurance for you. You are responsible for the deductible, share of cost and co-pay.

DEDUCTIBLE: A deductible is the amount of expenses that must be paid out of pocket by the patient before your insurance will pay any expenses.
CO-PAY: A co-pay is the fixed dollar amount that the patient pays for each office visit, and it is determined by the insurance plan.
a. All deductible and co-pays are due at time of service, or you will be asked to reschedule.
b. We DO NOT bill for deductibles or co-pays.
c. If you are in between insurances, then we will temporarily collect cash for office visits. This amount must be paid at time of service.
Balances: A balance may accrue for any services that are not covered by your insurance plan.
a. It is the patient's responsibility to pay your remaining account balances
b. All outstanding balances are subject to monthly finance charge of 5%
c. All balances that are more than 90 days past due will be sent to a collections agency, resulting in your dismissal from our practice.
d. There is a $40 fee for all accounts sent to collections.
e. Payment arrangements may be made with our billing department prior to being sent to the collection agency.
f. Our accountant requires that payment plans not be extended for more than 6 months.

I authorize payment of medical benefits to be paid directly to the physician for services rendered. I authorize my physician to release any medical information that is necessary to process claims with my insurance companies.

I have read and accept the above. I agree to be responsible and pay for my unpaid charges and balances not covered by my insurance.

_____ _____ _____

Signature Date SSN#

If patient is a minor (under 18 years old), then the responsible part (parent or guardian) must sign above and complete the following information:

Name of responsible party: _____ DOB: _____

Relation to Patient _____ SSN#: _____