**HILLBROOK FAMILY MEDICINE, P.C.**
Andrea Pfeifer, D. O.
Board Certified Family Practice

## OUR FINANCIAL POLICY

We would like to welcome you to our medical facility; we strive to provide quality care for our patients in a pleasant comfortable atmosphere.

If you are covered by health insurance, we will gladly submit the necessary forms to your insurance company. From our experience, we have found that few insurance plans cover the complete cost involved. Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claims or accept responsibility for negotiating your claims. If you do not have insurance, payment is due at the time of service. Co- payments are due upon arrival of your office visit. You will be required to pay your co-insurance payment and any deductible in full. We will also file your secondary insurance with proper information.

We accept checks, money orders MasterCard/Visa Debit Cards/Discover /American Express as payment. A monthly billing statement will be sent to you to inform you of your account status and any outstanding charges. If payment can not be paid in full
Please call the office to make payment arrangements. Return check fee will be $25.00.

If an account is overdue 90 days a collection fee of $35.00 will be added to your account or responsible party.

_____ Date_____ I have read and understand this policy.
Signature of Patient (Parent if Minor)

## ASSIGNMENT OF BENEFITS

I hereby authorize payment of all medical insurance benefits, which are payable to me under the terms of my insurance policy, to be paid directly to the medical facility/physician for services provided. I further authorize the release of any necessary information, including medical information from this office, to my insurance carrier (or in the case of Medicare Part B benefits to the Social Security Administration and Health Care Financing Administration). A copy of this authorization may be used in place of the original. I certify that the information I have provided is true and correct. I am aware that knowingly providing false information regarding my identity, insurance coverage etc. constitutes fraud. I understand and agree that I am financially responsible for charges not paid by my insurance company and will be charged a $35.00 collection fee should my account become delinquent.

_____ _____
Signature of Patient/Insured (Parent if Minor) Date