Family Practice of Jeffersonville, LLC

Jeffersonville Family and Geriatric Medicine, LLC

190 West Germantown Pike Suite #155, East Norriton, PA 19401-1383

Phone: 610-277-9040 Fax: 610-277-7890

FINANCIAL POLICY

We would like to welcome you to our office and assure you that we will do our utmost to provide you with the best care possible. If you have any questions regarding the following financial policies, please do not hesitate to speak with the office manager.

PATIENTS WITHOUT INSURANCE COVERAGE:

You will be requested to pay for services the day they are rendered. We are unable to bill you. We accept several forms of payment including cash, debit-card, personal check and credit card (VISA, MASTERCARD, DISCOVER and AMEX).

PATIENTS WITH INSURANCE COVERAGE:

Understanding your insurance coverage can sometimes be a challenge. We care for patients who receive insurance by many different employers and insurance companies. Each employer pays an insurance premium for specific coverage that fits his or her company's budget. Each plan is slightly different in it's covered services. It is your responsibility to be informed of your specific policies coverage, exclusions, co-pays, co-insurances, deductibles and maximums.

OUR RECCOMENDATIONS FOR TREATMENT WILL BE MADE APPROPRIATE TO YOUR MEDICAL NEEDS REGARDLESS OF YOUR INSURANCE STATUS.

Our courtesy service to insured patients includes:

1.) Filing your claims promptly and requesting payment of your benefit to our office.
2.) Following medical association guidelines for claims coding and filing.
3.) Providing you with any information known to us in dealing with your insurance.

Our expectation of you, the insured and/or owner of the policy:

1.) Payment of fees not covered by your insurance plan at the time the service is delivered.
2.) Understand that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier.
3.) Keeping our office informed of any changes in your insurance coverage or employment.

I hereby authorize FAMILY PRACTICE OF JEFFERSONVILLE, LLC and/or JEFFERSONVILLE FAMILY AND GERIATRIC MEDICINE, LLC to release to my insurance company any information required in the course of my care. I authorize benefits to be paid directly to FAMILY PRACTICE OF JEFFERSONVILLE, LLC and/or JEFFERSONVILLE FAMILY AND GERIATRIC MEDICINE, LLC. I understand I am responsible for all fees incurred, regardless of the status of my insurance.

X: _____ Date: _____ / _____ / _____

SIGNATURE OF PATIENT OR RESONSIBLE PARTY