ANNAPOLIS FAMILY MEDICINE

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Payment Policy

Patient Name: _____ DOB: _____

1. **Insurance**. We participate in most insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan, we participate 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.
2. **Copayments and deductibles**. All copayments and deductibles must be paid at the time of service. This requirement is part of your contract with your insurance company.
3. **Non-covered services**. Please be aware that some services you receive may be non-covered or not considered reasonable.
4. **Proof of insurance**. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **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.
6. **Non-payment**. 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 may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
7. **Missed appointments**. Our policy is to charge $75.00 for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

I have reviewed and agreed to the above AFM Patient Payment Policy.

_____ _____

Patient/Representative Signature* Date

*Signing will hereby acknowledge receipt of the AFM Payment Policy.