AGEWELL MEDICAL ASSOCIATES, PC
FINANCIAL PAYMENT POLICY

Thank you for choosing our practice! Our providers and staff are committed to the success of your treatment and care. The purpose of this form allows AgeWell Medical Associates to treat you, bill your insurance plan, share information with other health care offices/facilities, and to collect your account. If you need further information about the policy, please ask to speak with our Billing Administrator or Office Manager.

REGARDING INSURANCE: Our office participates with Medicare and many Medicare Fee For Service insurance companies. Should your insurance coverage be with one of these companies, we will bill them according to the established guidelines. However, co-payments, co-insurances, deductibles, and non-covered services are your responsibility and payment is expected at the time services are rendered. We accept payments by check, cash, or credit card. As a courtesy to you, we will submit a claim to your secondary insurance company but we will **not** bill more than two insurance plans.

SPECIAL NEEDS: There are times when making a payment can be a financial hardship. It may be necessary to set up a payment plan if you cannot comply with our financial policy. If you are in need of special payment arrangements, please advise our staff prior to your visit. Co-pays are exempt from this because your insurance requires you to pay your co-pay at the time services are rendered. If this is an auto accident visit, you are required to notify us at the time we see you to avoid additional financial costs.

I authorize treatment by the providers of AgeWell Medical Associates, PC and authorize the release of any information requested by insurance companies or liable third parties. I assign any insurance benefits to AgeWell Medical Associates, PC. If I do not provide correct insurance information to AgeWell Medical Associates, I will be responsible for the bill.

I hereby understand the financial policy of this office. I guarantee payment of all charges incurred for my account.

- **THE FEE FOR A RETURNED CHECK IS $25.00**
- **A FEE WILL BE CHARGED PER FORM. EXAMPLE: LONG TERM CARE, FMLA, OR DISABILITY.**
- **CO-PAYS ARE DUE IN FULL ON DATE OF SERVICE.**
- **INSURANCE INFORMATION SUBMITTED TO US PAST THE TIMELY FILING DATE, WILL BE YOUR FULL FINANCIAL RESPONSIBILITY.**

Financial Payment Policy and Privacy Notice Received

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Patient/Guardian/Legal Representative's Signature Date