Raymond M. Thomas, MD, PC   Acct # _______________

PATIENT FINANCIAL POLICY

Thank you for choosing Dr. Thomas for your gastroenterology needs. We are committed to providing quality medical care.

Our goal is to provide and maintain a good physician-patient relationship. Letting you know our office policy in advance allows for a good flow of communication and enables us to achieve our goal. Please read each section carefully and sign below. If you have any questions, do not hesitate to ask a member of our staff. A copy of this policy is available to you upon request.

- If an appointment is missed or cancelled within 24 hours, a charge of $25.00 will be applied to your account.
- Payment not received within 30 days will incur a late charge of $10.00. For every 30 days thereafter a debt remains unpaid an additional 2% will be added to the debt.
- Returned checks are subject to a service charge in addition to the bank NSF charge and will terminate your privilege to pay by check on future visits.
- It is understood and agreed that in the event any outstanding balance is referred to a collection agency or attorney for recovery, the patient will be fully responsible for all costs incurred by Dr. Thomas' office. This includes, but is not limited to collection agency costs and attorney's fees, in addition to the original debt.
- Coverage, co-pays and deductibles vary, even within insurance companies. **Please check with *your* insurance company before your appointment to be sure of what is covered under your individual policy.**
- You are personally and fully responsible for the payment of all charges for ________________________. Specifically, you will pay in full all balances due, including, but not limited to, balances due as a result of co-insurance amounts, deductibles, co-payments, and amounts due after the exhaustion of your insurance benefits (including, but not limited to, health care insurance). Your payment obligations shall at all times be subject to the provisions of your insurance coverage and applicable laws and regulations.
- **Office Visits:**

  Co-payments can NOT be billed. Full payment is expected at the time of service. This includes:

  a. **Insurance Co-payments** – the contractual obligation you have with your insurance provider.
  b. **High Deductible Plans** – until the deductible is met, a $40.00 payment is due at the time of visit.
  c. **Any balance on your account**.
  d. **Self-Pay Patients** (those patients without insurance coverage) – payment in full is due at the time of service. A fee schedule is available upon request. If you have been approved for a Sliding Fee scale from FF Thompson Hospital, our office will accept that sliding scale fee.

  Please speak to our billing staff if there is a hardship or obstacle for payment.

- **Procedures:**

  a. A bill for any balance due after insurance processes your claim, including any co-pay, will be mailed to you.

  b. You may receive a separate bill from FF Thompson Hospital for their services.

By signing this form, I am acknowledging that I have read, understand, and agree to the above Financial Policy.

Patient Signature ____Print Name____

Responsible Party Signature ______________________________Print Name & Relationship___________________________

Date: ______________________

(Sep 2011)