HOLY FAMILY CATHOLIC CLINIC

Assignment of Benefits, Practice Policies, & Privacy Notice

Financial Responsibility: All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments. As a courtesy, we will bill third party payers (such as auto insurance related to motor vehicle accidents) when provided with complete insurance information at time of service. Balances for third party claims are subject to the same payment terms as other services received at Holy Family Catholic Clinic, P.S. If you are unable to pay within 30 days of receiving service, please contact our office to set up a payment plan. Accounts may be assigned to an outside collection agency and reported to the credit bureaus when the personal balance is over 120 days old and/or payment plan payments are missed. Patients whose account has been assigned to outside collections are responsible for all agency and/or legal fees incurred. Thereafter, future services are on a cash basis with no extension of credit and may also be subject to dismissal.

"No Show" & Appointment Cancellation Policy: Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, we reserve the right to charge a fee of $75 for all missed appointments ("no shows") and appointments, which, absent a compelling reason, are not cancelled with a 24-hour advanced notice (unless prohibited by law). "No show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" in any 12-month period may result in termination from our practice. Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

Additional Fees: $50 returned check charge added to accounts for which check payment is not honored by the bank.

Assignment of Benefits: I hereby assign all medical and surgical benefits, to include major medical benefits, to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment checks directly to Holy Family Catholic Clinic, P.S. for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. Please contact your insurance company directly to discuss your specific benefits and/or limitations. We are happy to assist whenever possible regarding general insurance benefit questions. We cannot quote nor do we guarantee insurance benefits.

I have requested medical services from Holy Family Catholic Clinic, P.S. on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable at the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Notice of Privacy Practice: I also acknowledge that I have been given a copy of the office's Notice of Privacy Practice and understand that I can request another copy at any time.

Patient Name (*Please Print*): _____

Patient/Responsible Party Signature: _____ Date: _____