Patient Agreement of Financial Responsibility

Thank you for choosing **Family Medical and Maternity Care, P.C.** as your healthcare provider! We are committed to providing the highest level of care for you and your family.

Please read our practice's financial policy outlined below. Your signature of acknowledgement is required prior to the start of any treatment.

- It is your responsibility to ensure that FMMC has your most up-to-date and accurate health insurance information, mailing address, and contact phone numbers. It is also your responsibility to ensure that one of the FMMC physicians is listed as you Primary Care Provider (PCP) with your health insurance plan, as this may affect claim coverage.

- It is your responsibility to know the details of your health insurance plan, including benefits and out-of-pocket coverage details. If you are uncertain of the specifics or have additional questions regarding your plan coverage, please contact your health insurance company (their member services phone number should be listed on your health insurance card)

  Your health insurance policy is a contract between you and your health insurance company/employer and we are unable to change any of the plan specifics and do not have any control over the amount of your copay or deductible.

- We require that you bring your health insurance card, copayment, and photo ID to all of your appointments. Copays are due on the date of service and are collected during the check-in process. We accept cash, checks, most major credit cards, and HSA/FSA cards.

  Please note: Checks are not accepted for out-of-pocket expenses or non-covered services. Returned checks are subject to a $25 fee and any future balances will be required to be paid by cash or credit card only.

- Financial balances from copayments, coinsurance, and/or deductibles are determined by your insurance policy. Billing statements are mailed out on a monthly basis and payment is expected within 30 days of the statement date. If you are unable to pay your balance off in full, please contact our billing department to set up a payment plan.

  Failure to make a payment after three statements may result in your balance being forwarded to a collection agency and your account placed under review for discharge from the practice.

- For financial balances received as a result of diagnostic imaging (radiology), ultrasound, or laboratory services, please contact the billing department of the company from which you received the bill.

__________________________	__________________
Patient's Name	*Patient's Date of Birth*
__________________________	__________________
Signature of Patient/ Responsible Party	*Date of Signature*
__________________________	__________________
Name of Financially Responsible Party if different from patient (please print)	*Relationship to Patient*