Ponderosa Family Physicians Amendment to Primary Care Financial Policies
Acknowledgement of Financial Policies for Endocrinology
Effective 10/17/2017

Please understand that we consider it a privilege to partner with you in your medical care. However, the following policies are in place to help keep your account with us current and in good standing.

- Payment is due at the time of service for all co-payments and for services that are not covered by your insurance. If you cannot pay your copay at the time of your appointment, we will have to cancel your appointment and we will allow you to reschedule one time.
- If your deductible has not been met at the time of your appointment, you will be asked to pay the charges for your visit up to your deductible. If the amount remaining on your deductible is unknown, you will be required to pay $200 for your initial visit and $100 for follow up appointments.
- If you are uninsured, full payment is due at the time of service. All uninsured new patients will require a $200 deposit prior to being seen. All uninsured established patients need to place a $100 deposit prior to being seen. If there is a balance due after the charges for your visit have been entered, they need to be paid before you leave. Any charges not available at the time that you check-out will be due upon receipt of your statement.
- It is your responsibility to make sure that all contact, billing, and insurance information is up to date with us. If we do not have the correct insurance and contact information we cannot bill your insurance accurately and you will be responsible for any balance owed.
- Please be advised that it is your responsibility to know your insurance benefits. If, for any reason, your insurance company does not pay for a visit, full payment is due upon receipt of a statement from our office. If you have a dispute or appeal with your insurance company about their payment to us, it is your responsibility to negotiate with them for payment or reprocessing. We are glad to assist you with this dispute with documentation if needed. However, while the dispute is being resolved, payment in full is expected.
- If you have a balance due and our Billing Department does not receive payment within 30 days from the date of your first statement, you will need to pay your balance due prior to scheduling any appointments with us. If the Billing Department does not receive payment within 90 days from the date of your first statement, your balance will be sent to an outside collection agency. If your balance is sent to a collection agency, you could be permanently dismissed from our practice.
- For your convenience, we accept cash, check, Visa, MasterCard, or Discover for payment. **We also accept payments online at www.ponderosafamily.com**.

- A $20 charge will be assessed for all returned checks. If a check is returned to us for non-sufficient funds (NSF), we will no longer be able to accept checks for payment. You will need to pay all balances via cash, money order or credit card going forward.
- A no show is any failed appointment whether it is confirmed or not. This includes any appointment not cancelled 24 hours in advance. This also includes situations where a patient shows up too late for their appointment to be seen. (Please remember you can only cancel an appointment by calling the office. You cannot do this with the automated calling system or online.) Patients, and their family members when applicable, will be permanently dismissed from our practice after 3 no shows per individual or 5 no shows per family in a 3 year period. The following protocols will be followed:
    - New patient No Show: If you fail to keep your first appointment, you will not be able to reschedule with our office.
    - Established patient 1st No Show: A charge of $50 for all office visit appointments will be assessed and a $100 charge for all procedures will be assessed.
    - Established patient 2nd No Show: Charges are the same as 1st no show.
    - Established patient 3rd No Show: Charges are the same as 1st no show and dismissal from the practice.

I, (PRINT NAME) _____,
acknowledge receipt of the above financial policies and I agree to abide by them.

_____ _____

Signature of Patient/Guardian Date