UNION PHYSICIAN SERVICES
A DIVISION OF UNION HOSPITAL

Financial Policy

I am pleased to provide your family's health care needs. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which you will need to read and sign.

All patients or their legal representative shall complete an information and insurance form before seeing the doctor.

- Co-payments are due at the time of service.
- We accept cash, checks, and credit cards. Returned checks will be subject to a $25.00 fee.
- Auto accident claims are your responsibility.

REGARDING INSURANCE:

Presenting correct insurance information at the time of service is the patients/ guarantor's responsibility. Failure to produce verification of guarantor insurance information will result in a patient status of "Self-Pay" and payment will be due at the time of service.

Your insurance coverage is a contract between you and your insurance company. The Physician office is not a party to that contract. Not all service provided to you by the Physician office may be considered covered by your insurance company. It is your responsibility to know what service is covered under your policy and to check with your insurance company to verify whether the service to be provided is covered. As a standard procedure, the Physician office will bill your insurance company for the service rendered. The Physician office will attempt to identify and inform the patient when it becomes aware of non-covered services.

_____ I agree that, should the service not be covered or paid by my insurance company, I will
Initials be responsible for payment of the amount billed by the Physician office for the service rendered.

USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MINOR PATIENTS:

The adult accompanying a minor is responsible for services rendered for the minor.

MISSED APPOINTMENTS:

As a courtesy to our other patients please contact the office with a 24 hour notice if you need to cancel an appointment. If you fail to keep an appointment three times without calling to cancel, you may be terminated as a patient.

We understand that temporary financial problems may arise and affect timely payment on your account. Please contact our office promptly for assistance in the management of your account.

HIPAA PRIVACY DISCLOSURE AND USE ACKNOWLEDGEMENT

I acknowledge that I have received a copy of or have reviewed the posted HIPAA Privacy Disclosure statement and use of medical information for services rendered to me by physicians under Union Physician Services, LLC. I understand that my medical record may be accessed by all Union Physician Services offices for medical necessity.

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Print Name Signature of Adult Patient/ Parent or Guardian

_____

Date