Healey Medical Practice
25 Park Street Canton, NY 13617
(315) 379-9158

Financial Agreement
Patient Name: _____

Office/Financial Policy Agreement

Thank you for choosing Healey Medical Practice for your medical care. We are committed to providing you with quality, personal health care, and appreciate your commitment to adhere to this Office/Financial Policy Agreement. By understanding our policy, we can provide you with the best service. Agreement with this policy is required for all medical care.

Except as indicated below, ***payment is required at the time services are provided*** unless other arrangements have been made in *advance*. We accept cash, personal in-state checks, VISA, MasterCard, Discover and American Express credit cards.

INSURANCE:
We participate in most insurance plans and will bill your insurance for services rendered. If we do not participate with your insurance plan, payment in full is required at the time of service, unless other arrangements have been made in advance. Knowing your insurance benefits- including eligibility, copays/deductibles, covered benefits and medically necessary procedures is ***your*** responsibility; please contact customer service at your insurance company for questions you may have regarding your coverage. ***You are responsible for any charges not covered by your plan.***

***Proof of insurance**: All patients must provide update to date patient information at each office visit. You must furnish valid and up to date proof of insurance coverage and a copy of your driver's license. If you provide false or expired insurance information you will be responsible for the balance of the claim. **Please notify us of any changes in insurance coverage prior to time of service.** Insurance denials for termination of coverage will be automatically billed to you.

***Copays and deductibles**: All copays and unsatisfied deductibles must be paid at the time of service. By contractual law your insurance company requires us to charge for, and you to pay for, all required copays, co-insurance, deductible and non-covered services.

***Claim submission**: We will submit your insurance claims and assist you in any way reasonable to help get your claim paid. Your insurance company may need you to supply information directly to them. It is your responsibility to comply with their request in a timely manner.

OUT OF NETWORK CARE/SELF PAY:
Payment will be due in full at time of service. For our out of network patients, we will bill the charges from your visit to your insurance plan. Any reimbursement from your insurance will be sent directly to you. Our self pay patients will be offered a 15% reduction from our usual fees when paid in full at time of service.

Date: _____ Signature: _____

Printed name of person signing form (if other than patient): _____