FINANCIAL POLICY

The practice of Columbus W. Floyd, M.D. has an obligation to provide quality care and assist our patients with getting their insurance company to pay their bills appropriately. As a courtesy, we will file your insurance claim with our practice's participating payers . We must collect your co-payment, deductible and/or co-insurance prior to services being rendered. It is our policy to inform you of our payment procedures.

Please review the section below and initial that which is applicable to you.

______ PATIENT WITH INSURANCE
You are responsible for deductibles, co-payments, non-covered services, coinsurance and items considered "not medically necessary" by your insurance company. Please pay co-pays, coinsurance and deductible amounts at the time services are rendered. The remaining balances should be taken care of within (1) month of notice from the insurance company. If you or your insurance carrier makes payment exceeding your balance, reimbursement will be remitted. If payment cannot be made at each visit, please notify the front-desk staff to make other arrangements.

_____ PATIENT WITH MEDICARE
Our office will submit your charges to Medicare and your secondary insurance carrier. You will be responsible for deductibles, coinsurance and any non-covered services.

____ PATIENT WITHOUT INSURANCE (Private Pay)
Please make full payment for your care prior to each visit. If payment cannot be made at each visit, the front-desk staff will assist you in working out possible payment arrangements. (See below)

ADDITIONAL MISCELLANEOUS CHARGES

INSUFFICIENT CHECKS
When a check is returned to our office, it is the patient's responsibility to pay the debt due and any associated fees. Our fee for insufficient funds is $30. Debts must be paid back by method of cash, money order or credit card within 30 days from occurrence.

MEDICAL RECORDS AND FORMS
Requests for copies of Medical Records or forms to be completed by your doctor or medical staff in regards to Disability FMLA (Family Medical Leave Act), Life insurance and other appropriate sources requiring the extra time of the physician is $25 at time of service.

PAYMENT ARRANGEMENTS
For established patients, we will be happy to assist you in making payment arrangements when necessary. Payments must be received no later that the 30th of every month. If payment is not made by the 30th, you must contact our office to discuss your next payment. Timely payments must be made or your account will be considered in default and may be turned over to Collections. (Additional expenses incurred are not a part of the original agreement and will be due at the time of service.)

I have read and agree to the Financial Policy stated above that applies to me and I agree with the financial arrangements outlined on the form.

Patient Name **DOB:**

X____
Patient or Responsible Party Signature Date

X____
Printed Name of person signing on behalf of Patient and Relationship