Hope Medical Clinic P.A

3609 Cape Center Drive, Fayetteville, NC 28304
Phone: 910.500.0909 Fax : 910.920.4224

Financial Policy and Assignment of Benefits

Patient's Name: _____ **D.O.B:** _____

Payment is due in full at time of Service: for all patients who have an insurance policy with which we have no contractual relationship and for patients who have no insurance. We will file your claim to your insurance company as a courtesy. A delayed or non-paid claim by your insurance carrier is not the responsibility of Hope Medical Clinic, PA. If there are any past due balances on your account Hope Medical Clinic, PA will require that the past due balance be paid in full or payment arrangements be made before any new appointments will be scheduled. The providers reserve the right to cancel any appointments, if balances are not resolved. We reserve the right to turn any patient over to collections, if it is deemed that the account has been in default of payment obligations or for noncompliance of the policy. If we turn your account over to a collection agent, you will be responsible for administrative fees. Patients previously sent to collections are required to pay old balances in full and for all future visits.

Co-pays or Deductibles are due at Time of Service: for any patient who has an insurance plan with whom we are contracted.

The insurance carrier may bill deductibles, copay and co-insurance amounts to the patient after payment. Hope Medical Clinic, PA reserves the right to bill patient if the insurance company has not paid for the service within 60 days of the service. Any service that the carrier deems is non-covered service is the responsibility of the patient and will be payable in full within 30 days after receipt of billing statement.

Check payment Policy: There will be a $25.00 Return Check Fee to your account for every check returned to Hope Medical Clinic, PA for insufficient funds. Patients who issue two (2) NSF checks must make all payments by cash, money order or credit cards.

Disability Forms: Hope Medical Clinic, PA charges $30.00 per Disability Form, which is due at the time the form is turned in for completion.

Medical Record: Hope Medical Clinic, PA charges a minimum of $10.00 fee for the release of Medical Records. Invoice will be sent out and payment needs to be received before the record is released. Our fee schedule is:-

Page	Amount Charged per page
0 - 25	$ 0.75/ Page
26 – 100	$ 0.50/Page
100 & Over	$ 0.25/Page

Motor Vehicle Accidents or Liability Claims: Hope Medical Clinic, PA is not a third party to claims related to motor vehicle accidents or liability claims. The patient is responsible for all charges related to medical treatment received from Hope Medical Clinic, PA therefore, payment for charges are due at time of service.

Responsible Party: It is the policy of Hope Medical Clinic, PA that any patient who is 18 years or older will be responsible for all charges incurred. Patients under the age of 18 the parent or legal guardian will be financially responsible for all charges incurred.

Missed or late appointments: Hope Medical Clinic, PA will charge a no-show fee of $50.00 for new patients and $35.00 for existing patients for any missed appointments, if a notification was not received in our office 24 hours prior to the appointment time. If you are late for your appointment, Hope Medical Clinic, PA may consider you as a NO SHOW and reserves the right to charge a no-Show Fee.

Patients who do not comply with this policy may be dismissed from this practice in writing. Only emergency care will be provided for a 30 days period after dismissal at which time the patient should have been able to establish with a new physician.

Hope Medical Clinic, PA reserves the right to waive the above requirements on a case-by-case basis.

I have read and understand the financial policy and Assignment of Benefits of this practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to –time by this practice. I agree to be responsible for services determined not to be medically necessary or non-covered by insurance, this includes all insurance writing or replaced by one of a later date.

_____ _____

Signature of Patient Date