Office Financial Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please check in at the front desk and present your current insurance card at every visit. You will be asked to update your address and insurance information. This is your verification of the correct insurance and consent to bill them on you and/or your child's behalf. If the insurance company that you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan.

2. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. Copayments are due at the time of your visit.

3. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered. If you are having difficulty verifying coverage for our office visits, we can help to obtain this information.

4. If our physician and providers do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.

5. If you have no insurance, payment for an office visit is to be paid at the time of the visit.

6. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. For any balance not covered by your insurance, you will be billed by paper invoice. This amount is due within 30 days of invoice date. You must notify within those 30 days if you would prefer a different method of payment than billing your credit card on file.

7. We request that a valid credit card account number be kept on file at all times. This card will only be charged in the event that your statement balance Is overdue and you have not responded to our requests for payment. Your credit card details are encrypted and secured. Valid credit cards, bank-issued debit cards, and HSA/FSA cards are acceptable.

   Name on Credit Card_____ Signature_____

   Credit Card Number _____ Exp_____ Sec Code (Back of Card) _____

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8. If previous arrangements have not been made with our finance office, any account balance outstanding greater than 30 days will be charged a $20 re-bill fee. Any balance over 90 days will be forwarded to a collection agency.

9. We request 24-hour notice for canceling any appointments. There is a $50 charge for no-shows without notice/explanation. Your credit card on file will be charged for these no-show appointments.

10. A $25 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.

11. We may charge a fee per patient to copy or transfer medical records in excess of 10 pages, at a rate consistent with state and federal laws.

12. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.

I have read and understand this financial policy of Coraggio, LLC D/B/A Mobile Health Team and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s) _____

_____ _____

OR Responsible party member's name Relationship

_____ _____

Responsible party member's signature Date