THE MEDICAL CENTRE OF
LEHIGH ACRES, INC

1303 Homestead Rd. N. Suite # 102 Lehigh Acres, FL 33936-6049
Tel: 239-303-2700 Fax: 239-303-2756
www.lehighmd.com info@lehighmd.com

FINANCIAL POLICY

This is an agreement between **The Medical Centre of Lehigh Acres, Inc (TMCOLA)** and the Patient named on this form.

The words **"you", "your" and "yours**", mean and refer to, the Patient. The word **"account"** refers to the account that has been established in the Patient's name in which charges are made and payments are applied. The words **"we", "us",** and **"our"** refer to **TMCOLA.**

As a courtesy to you, we will bill your primary insurance company on your behalf. We will estimate what your insurance company may pay, but this is not a guarantee of payment. Your insurance company will make the final determination of your eligible benefits. You acknowledge that you understand that insurance coverage for benefits is an agreement by and between you and your insurance company. Therefore, you are accepting responsibility for the charges that your insurance company does not pay.

REFERRAL/AUTHORIZATION: Your insurance company may require a referral and/or preauthorization of some medical services. Should your insurance company require a referral and/or preauthorization for services, it is your responsibility to obtain said referral and/or preauthorization. By failing to obtain the proper referral and/or preauthorization, the insurance company may reduce or deny payment for services.

MANAGED CARE: All insurance companies require that Patient co-payments and deductibles are payable at time of service. If you are unable to pay at time of service, an additional charge of **$25.00** will be assessed to the balance to cover the additional collection costs. This service fee is Patient responsibility and cannot be billed to insurance.

MEDICARE: We participate in Medicare Part B and we will bill all services on your behalf. You are responsible for your annual Medicare deductible and the 20% Patient responsibility. You are responsible for any services that Medicare does not cover. We will bill your secondary insurance on your behalf.

SELF-PAY: If you are paying for services yourself (self-pay), then all payments for the services rendered are due at the time of service. If you are unable to pay at time of service for certain services, any remaining balance will be billed to you upon prior approval from the billing department.

WORKER'S COMPENSATION: At this time we are not affiliated, nor are we contracted with any worker's compensation carriers.

PERSONAL INJURY CASES/MOTOR VEHICLE ACCIDENTS: We submit bills for motor vehicle or personal injury claims. Patient must provide insurance information and coverage verification for services. Letter of protections from attorneys are accepted with prior approval from the billing department.

APPOINTMENT CANCELLATION: We require a minimum of 24 hours notice for cancellation of appointments. Failure to provide the minimum notice will result in a $30.00 **"no show fee"** charged to your account.

PATIENT BALANCES: If you have a Patient Balance on your account, you will be billed for the entire amount due. Your bill will show separately any previous balance, any new charges on your account, and any payments or credits applied to your account during that billing cycle. Your bill may also show pending payments from your insurance company, if applicable. The Patient Balance will be clearly indicated.

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Unless you have made other arrangements for payment of the Patient Balance approved by **TMCOLA'**s Billing Office writing, the amount indicated as Patient Balance is due upon receipt. Your balance will be past due if payment is not received within 30 days from the issue date printed on the statement. TMCOLA reserves the right to add any fees incurred for additional billing and/or collection services. For your convenience, we accept payment via all major credit cards, including bank debit cards.

If necessary**, TMCOLA** Billing Services may set up a regular payment schedule for you. **TMCOLA** reserves the right to report your account to credit reporting agencies if your balance goes into a past due status. Nonpayment of past due Patient Balance may result in **TMCOLA** inability to provide you with continued care.

You understand that if your account is submitted to an attorney, collection agency, involved in court litigation, or reported to a credit reporting agency, the fact that you received treatment/services at our office may become a matter of public record.

Transferring of medical records must be requested in writing along with a Medical Records Release form.

BY SIGNING BELOW, YOU ACKNOWLEDGE AND AGREE THAT:

You understand that it is your responsibility to provide **TMCOLA** with current and accurate billing information at the time of service and you will notify **TMCOLA** immediately if there are any changes to this information.

You agree to the terms and conditions contained herein. You understand that any charges not covered by your insurance company along with any co-payments and deductibles, are your responsibility.

You authorize your insurance benefits to be paid directly to **TMCOLA** for services rendered.

Agreement is effective on date agreement is signed below.

PATIENT NAME:_____

SIGNATURE OF RESPONSIBLE PARTY:_____

RESPONSIBLE PARTY/RELATIONSHIP:_____
(IF OTHER THAN THE PATIENT.)

DATE:_____