CLERMONT MEDICAL CENTER
FINANCIAL POLICY

PAPERWORK POLICY

Please note that insurance companies **will not** reimburse us for completing paperwork. We reserve the right to charge for the completion of forms, and other types of paperwork. The processing charge for these forms will start at $25 and will not exceed $200 per incident and will depend on the paper work required. Medical records will be charged at the rate of $1 for the first 25 pages and every page after that .25 cents for each additional page

SELF PAY POLICY

Patient is to pay for services in full and will get a discount if payment is made at the time of the visit. Any other service (test, procedure) other than the office visit, will be an additional charge due at time of service.

PATIENTS WITH INSURANCE

We are contracted with several insurance carriers and we will bill the insurance company for you. Copayments and deductibles are due at the time of service.

MEDICARE PATIENTS

We do file Medicare electronically and as a courtesy we will file your secondary insurance to Medicare. All Medicare deductibles are due and payable at the time service is rendered. We do not research insurance company denials.

AUTO ACCIDENTS

We will file your auto insurance for you. We will not file with a third party auto insurance or with an attorney. Our Billing & Insurance Departments needs the following information to perform a successful filing: Name and billing address of the auto insurance, claim adjuster's name and phone number, and the claim number. If there is a denial of your claims you will be held responsible for payment.

PATIENT NO-SHOW POLICY

Advance 24 hours notice is expected if you are not able to keep an appointment. You will be charged a $25 fee for missed appointments. And a fee of $15 for missed Lab appointments. We understand that, on occasion emergency situations may occur that prevent a 24-hour notice. These cases will be handled on an individual basis by our Insurance & Billing Department.

Name, Address and Phone Number of Contact In Case of Emergency	**Relationship**
1. ______________________________	1. ____________
2. ______________________________	2. ____________

I ______________________________ (Patient, Guardian, or Parent) am aware of Clermont Medical Center's Policy.

______________________________ Signature

______________________________ Print