Bobbi Edwards, MD, PC Financial Policy Acknowledgement Form

Thank you for choosing Bobbi Edwards, MD, PC as a health care provider. We value your patronage. Please be advised of the financial policy outlined below, which we require that you read, and sign prior to treatment.
Dr. Edwards participates with most major insurance companies. As such, we verify health insurance coverage and proper identity before each visit. Having current and accurate information allows us to process your claim promptly and correctly. We have discontinued mailing of monthly courtesy statements.
In order to comply with federal and state regulations, our financial policies are as follows.

IMPORTANT DETAILS – PLEASE READ ALL POINTS CAREFULLY:

- Patients are responsible for paying all *known* co-pays, deductibles and non-covered services as specified by their insurance plan coverage in effect, at check-in on the day of service. Cash and credit cards are accepted (personal checks are accepted from return patients only).
- BCBS Master Medical patients are responsible to pay their office visit charges in full at the time of service. Our office will, on the patient's behalf, bill a courtesy claim to BCBS.
- HMO patients are required to obtain an electronic referral form from their primary care physician prior to their appointment! HMO contracts do not allow Dr. Edwards to see patients without the appropriate referral on file. It is the patients responsibility to make sure that they have a valid referral with them, or know that the valid referral is already in our office on the day of the appointment, and know their referral's expiration date. We will not be able to contact a patient's primary care physician at the time of the appointment for an invalid or expired referral
- A credit card, debit card, or Care Credit account number will be held on file to cover any *unanticipated* co-pays, deductibles, or non-covered services, as determined by your insurance company after a claim has been billed. The card on file will only be charged after notification of an additional amount due from the insurance company. You will be notified before the charge, if requested.
- **If a credit card is not placed on file with an account, that account will be charged $5.00 for the generation and mailing of a statement. The account is considered delinquent after 30 days, and a $20.00 delinquent account fee will be assessed at the time of mailing a second statement.**
- Accounts are automatically sent to collections under the following circumstances: outstanding balance for 60 days, mail returned for changed address, account credit card denied for two months. Any account sent for collections will incur an additional 30% collection fee.
- All bank related fees for returned checks will be charged to the attached account in the event of a bounced check.
- **A charge of $25 will be assessed for each appointment missed or not cancelled at least 24 hours before the appointment time.**

Credit card to be used for account balances:

I authorize Bobbi Edwards, MD, PC to charge outstanding balances on my account to the following credit card:

Visa Mastercard Care Credit Other:_____

Acct # ___-___-___-___ / ___-___-___-___ / ___-___-___-___ / ___-___-___-___ Exp: ___ / ___

I wish to be notified of charges to my credit card in the following manner (choose only if notification desired):
□ Text (phone #) _____ □ Email _____

Name on card (please print)_____

Patient Name_____

Signature_____Date_____

If we have been supplied with insurance information, that insurance will be billed for medical services provided by Bobbi Edwards, M.D., P.C. Please be aware that some and perhaps all of the services provided may be non-covered services, or not considered reasonable and medically necessary under some insurance plans thus you may ultimately be responsible for your bill. As a result, your actual payment to Bobbi Edwards, M.D. may be greater than the standard co-pay required.
I have read this acknowledgement form carefully. I understand and agree to this financial policy.

_____ _____
Signature of Patient or Responsible Party Date

_____
Patient Name