**Patient Financial Agreement**

Thank you for choosing Sandpoint Family Health Center as your health care provider. We are committed to providing quality, comprehensive, and patient centered care while building a successful physician-patient relationship. An important part of that relationship is your clear understanding of our Financial Policies. To help you understand, we ask that you carefully read this policy. If you have any questions about this information, please ask to speak with a member of our billing staff.

**Billing Insurance and Patient’s Responsibility** In order to properly bill your insurance company, we require that you disclose all current insurance and demographic information. At each visit, please provide us with your insurance card and any changes to your name, address, or contact information. While every effort is made to collect from the insurance companies, patients are responsible for denied charges due to inaccurate insurance information.

We will do our best to help you understand your insurance benefits. However, it is ultimately your responsibility to know your benefits. The insurance company makes the final determination of your eligibility and benefits for services rendered, which may result in additional costs. We encourage you to contact your insurance company if you have any questions regarding your eligibility or benefits prior to your appointment.

If you have a concern regarding cost, please discuss any additional procedures with your physician *before* they are started.

**Self-Pay or Private Pay** If you have no insurance coverage, we a $100 down payment is due when you check in and the balance due at the end of your appointment. We will provide an estimate for the services requested at the time of scheduling. We offer a 50% discount on all professional charges to self-pay patients. This discount does not apply to procedures, labs, immunizations, or other in-office services. If a patient is unable to pay in full at time of service, a 25% discount will be applied to applicable services and a payment plan will be offered.

**Payment Expectation and Collection Policy**

Co-Pays are due at the time of your visit. If you do not pay your co-pay a $10.00 fee will be assessed.

In the event you acquire a past due balance, we will make several attempts to notify you using the contact information you provide. If there is no response to our efforts within ninety (90) days, the balance will be turned over to our collection agency. We may not schedule any future appointments until your past due balances are paid in full. Any balance that is transferred to a 3rd party collection agency will have discounts removed. The balance transferred to the 3rd party collection agency will be FHC’s full fee minus any payments that have been made.

**My signature certifies that I have read and understand the contents of the Patient Financial Agreement.**

Print Name Date of Birth

Signature Date