Dr. Thornblade's Financial Policies
Effective July 1, 2016

We are committed to providing you with the best quality medical care and welcome conversations about our professional fees at any time. The fees charged reflect the level of professional skill required, the complexity of your presenting complaints and medical history, and the time spent evaluating and treating you.

INSURANCE
Billing of insurance is a courtesy we provide to our patients and is not required by law. Please provide us with a copy of your current insurance card and a photo ID at your every visit and whenever there is a change in insurance. We may occasionally ask for additional copies. It is your responsibility to have knowledge of your annual deductible, co-pays, and out of pocket maximum. If your insurance company does not respond to us within 30 days of our submitting a claim, the balance will become your responsibility.

We will bill your primary insurance, and bill secondary insurance for any line item with a balance greater than $10. If you have balances smaller than $10, we ask that you pay us and submit claims to your secondary insurance for reimbursement.

CO PAYS
Your co-pay is determined by your insurance carrier. Your insurance contract requires that we collect your co-pay at the time of service, when you check in to be seen. Please be prepared to pay your co-pay at each visit. THIS APPLIES TO SHOT VISITS AS WELL.

REFERRALS
If your insurance plan requires a referral from your primary care provider or "Passport Provider" it is your responsibility to confirm that we have received it. If the referral is not complete, you may be required to reschedule, and/or the charges may become your full responsibility.

MISSED APPOINTMENT FEE
We are instituting a $25 fee for missed appointments. We understand that schedule changes arise and respectfully request 24 hours notice of your need to cancel an appointment so that we may keep our appointment slots filled. This $25 fee will be not be billed to your insurance carrier; it is your responsibility. This fee applies to all patients, regardless of insurance provider or coverage status.

NSF FEE
A fee of $30 will be charged to your account if your check is returned for insufficient funds.

SELF PAY/UNINSURED
We will collect a $200 deposit on the day of your appointment from you before being seen by the provider. The balance will be collected following your appointment.

HIGH DEDUCTIBLE PLANS
If you have not met your deductible, or do not know if you have met your deductible, we will collect a $200 deposit from you on the day of your appointment before being seen by the provider. The balance will be collected following your appointment.

ACCOUNTS WITH OUTSTANDING BALANCES
If you have an outstanding balance at the time of your appointment, we need to collect that balance, or a portion of that balance up to $200, before you may be seen by the provider.

Initial____________

PAYMENT PLANS
Once you receive a statement from our practice, please pay in full upon receipt. For your convenience, we accept cash, personal checks, debit and credit cards and Care Credit to assist you in paying your balance in full. If you cannot pay your balance in full, a short-term payment plan may be created to pay your balance over 3-6 months. You will be sent a letter stating the budget plan and the terms of re-payment.

COLLECTIONS
We refer accounts to an outside collection agency if we fail to obtain payment through usual methods of mailing patient statements to the account guarantor. Please keep us informed of address and phone number changes which helps us to stay in contact with you.

If your account is referred to our collection agency, any further visits to our practice will require your payment in full at the time of service. We will still bill your insurance for the visit and issue you a refund if necessary.

By signing below, you indicate your understanding that in the event any unpaid balance is placed for collections with any third party collection agency, a fee of 33.333% of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly to collect amounts owed under this agreement such as court costs, attorney fees, late fees, and any other fees so stated elsewhere. The authorized fee of 33.333% and the additional costs and charges listed above represent the actual costs incurred by Carl E. Thornblade, MD, PLLC to collect amounts owed under this agreement and a corresponding decrease in expected revenue resulting from this signer's failure to pay as specified in this agreement.

By signing below, I agree that I have read and agree to this financial policy.

____________________________________ __________________

Responsible party signature date

____________________________________ __________________

Responsible party name, printed date

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Patient name (if different from Responsible Party)

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Staff signature date