

Holmes Family Medicine, Inc.
Payment Policy — Effective June 1, 2004

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Self Pay.** Self pay patients are considered those who do not have medical health insurance coverage. **Payment in full is expected at each visit.** As a courtesy, we will provide a 15% discount for each Office Visit when payment is made.

2. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted except in special cases of financial hardship approved by the physicians. Please be aware that if your balance remains unpaid, we may refer your account to a collection agency, and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and/or certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physicians will only be able to treat you on an emergency basis.

3. **Missed appointments.** You may be charged a No-Show fee of \$25 - \$75, depending on the type of visit, for missed appointments that are not cancelled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointments.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding the payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient/responsible party

Date of birth

Today's date

****List ALL family members (with their date of birth) under the age of 18 residing in your home who attend this office:**
