



## **PRACTICE INFORMATION AND PAYMENT POLICY**

Welcome to Gateway Family Medical Center. Our clinic is open Monday through Friday 9:00am until 6:00pm.

You have been given this Practice Information and Payment Policy sheet to read and sign, along with a Patient Information sheet. Once you have completed these forms, please return them to the receptionist along with your insurance card (s) and a picture ID to copy for your chart.

### **PATIENT RESPONSIBILITY**

It is the patient's responsibility to know what the insurance does and does not cover. In addition, it is the patient's responsibility to verify whether the physician you are seeing is contracted with your insurance plan. You can find out more about insurance by calling member services or by calling your human resources department at work.

### **APPOINTMENTS AND WALK-INS**

If you have an appointment, we will do our best to see you at your appointment time. However, there may be circumstances such as emergencies or walk-in patients that may prevent us from seeing you at your exact appointment time. If you are coming in on a walk-in basis, we will be working you into the schedule and do our best to see you as quickly as possible. However, scheduled appointments take priority (with the exception of emergency medical situations).

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### **PAYMENT POLICY**

You are responsible for paying your copayment at the time of service. We accept cash, check, Visa and MasterCard. If you do not have a method of paying your copayment, please see the receptionist to reschedule your appointment (new and established patients). Patients that will be paying for their services will be required to leave a deposit before being seen by the physician. We will collect either a credit card, check, or a cash deposit. Please stop by the front desk before you leave to verify whether additional payment is due or a partial refund.

It is Gateway Family Medical Center's policy to verify insurance coverage every 30 days for all patients. If we are unable to verify your insurance coverage, you may be asked to pay for your visit at the time of service. We will call to advise you whether we were able to verify your coverage. If insurance has been verified, we will with credit your credit card minus your co-pay or mail your check back to you.

### **INSURANCE BILLING**

By signing this form you are authorizing Gateway Family Medical Center to bill the insurance that you have provided. You will also be requesting that payment for medical services that were provided to be sent to Gateway Family Medical Center.

As a courtesy, we will bill your insurance and wait 60 days for payment. If we have not heard from your insurance carrier within the time allowed, the balance will become the patient's responsibility (excluding HMO patients through SCCIPA).

### **OUT OF AREA PATIENTS**

We require that you pay at the time of service by cash, check or credit card (exception: Medicare). We will give you an itemized bill that you may submit to your insurance carrier for reimbursement.

### **ESTABLISHED PATIENTS**

You will be asked to verify your patient information on every visit. **Please notify the receptionist immediately if there are any changes to your personal or insurance information.**

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_

If minor,

Parent/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_

**CONFIDENTIAL CHANNEL COMMUNICATION REQUEST**

As required by Health Information Portability and Accountability Act of 1996 you have the right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you're making your request, and will make reasonable efforts to accommodate all reasonable requests.

I, \_\_\_\_\_ (print name) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. **This request supersedes any prior request for confidential channel of communications I have made.**

**Please check all that applies.**

**YES**

**NO**

**I want you to contact me by phone**

\_\_\_\_\_

\_\_\_\_\_

**Leave a detailed message on answering machine**

\_\_\_\_\_

\_\_\_\_\_

**E-mail**

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