

FAMILY PRACTICE PHYSICIANS, INC.

10301 Glacier Hwy · Juneau, AK 99801 · Tel: 907-789-2910 · Fax: 907-789-5545

OUR FINANCIAL POLICY

We are committed to the success of your medical treatment. Please understand that payment of your bill is part of this treatment. We want you to completely understand our financial policies.

1. Payment is due at the time of service unless other arrangements have been made in advance with our billing office. We accept cash, checks, debit cards and all major credit cards.
2. There is a \$35.00 returned check fee on all returned checks. After the first returned check we will only accept cash or debit/credit cards.
3. We will bill your insurance company as a courtesy. Copayment and deductible is due at the time of service. Keep in mind that your insurance policy is a contract between you and your insurance company. If your insurance company does not pay the claim within 60 days from submission date, it is your responsibility to pay the balance due. If we receive a check from your insurer after you have paid, we will refund any overpayment to you. It is also your responsibility to make sure we have current insurance information.
4. Not all insurance plans cover all services. In the event your insurance determines a service to be “not covered” or “bundled fees”, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
5. Patients with a balance over 90 days will be sent to collections. The collection agency does charge interest.
6. **Cancellation of an appointment must be made 24 hours prior to your appointment time. Failure to cancel and missed appointments will result in a \$25.00 fee. Your insurance does not cover this fee.**
7. If it has been more than three years since your last visit at Family Practice Physicians, you will be considered a new patient.

I have read and understand the financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time. This policy also supersedes any previous policy I may have signed with Family Practice Physicians.

Printed Name of Patient

Date

Signature (or responsible party if minor/ print name if different than patient)

