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NAME : _____

Patient Financial Policy

Thank you for choosing Joy Internal Medicine for your health care needs. The patient financial policy has been developed to assist in answering your questions regarding patient and insurance responsibility for services rendered. Your understanding of and compliance with our patient financial policy is important. Please read the policy below and ask the staff any questions you may have and sign as indicated. The original will be maintained in your file and a copy may be provided to you upon your request.

1. PROOF OF INSURANCE: All patients must complete our patient information form before seeing the physician. If you are not insured by a plan that we participate with, payment in full is expected at each time of service. It is your responsibility to ensure that we have your correct information and an up-to-date copy of your insurance card.

2. UPDATED CHANGE OF INFORMATION & COVERAGE: We will ask you to update this whenever you have a change in address, employment, insurance, etc. However, it is your responsibility to make us aware of these changes and if you fail to provide us with the correct updated information, you will be responsible for the entire cost of the services rendered and immediate payment will be expected.

3. CO-PAYMENTS, DEDUCTIBLES & CO-INSURANCE: All co-payments, deductibles & co-insurance must be paid at the time of service. Payment of your copayments, deductibles & co-insurance is part of your contract agreement with your insurance plan. Our failure to collect payment may be a violation of billing compliance and may be considered as an act of fraud by your insurance plan.

4. NON-COVERED SERVICES: Please be aware that some or perhaps all of the services you receive may not be covered or considered reasonable or necessary by your insurance plan. If you elect to have these services, you will be asked to sign a waiver and payment in full at the time of service will be expected.

5. PRIMARY CARE SELECTION: Some plans require patient to designate primary care physician before seeing Dr Kim. It is patient's responsibility to find out if your plan requires this and must be done prior to visit. If claim is denied due to this reason, it is patient's responsibility.

6. CLAIMS SUBMISSION: We will submit your claims and assist you in any way we can to help get your claims paid. Your insurance plan may request information directly from you. Your failure to timely comply to your insurance plan's request may result in your claim denial and if so, will result in our seeking full reimbursement from you for services rendered; even if we are a participating provider with your plan. Your insurance benefit is a contract between you and your insurance plan.

7. SELF-PAY: If you do not have valid health care coverage, you will be considered as self-pay. Payment in full is due at the time of service.

8. NON-PAYMENT: If your account is over 60 days past due, you will receive a statement indicating that you have 30 days to pay your account in full. Partial payments will not be accepted unless you have contacted our office and otherwise negotiated. Please be aware that if a balance remains unpaid, we will turn your account over to a collection agency after the 90th day past due.

9. RETURNED CHECKS: A returned check fee of $30 will be added to your account for every check returned for insufficient funds, stopped payment or closed accounts. After the second occurrence, only cash or credit card payments will be accepted.

11. NO SHOW POLICY: We respectfully request a minimum of 24 hours advance notice for office visit and procedure appointment cancellation. A fee of $20 for a missed office visit without a notification will be required and enforced. If you miss 3 or more visits without canceling or rescheduling 24 hours in advance you may be dismissed from our practice

12. Medication Request: We do not provide prescription for a new medication without an office visit. However, in some urgent cases, medication can be faxed to your pharmacy and patient will be charged an office visit co-pays. (Patients without $0 copay will be charged with $20.)

*****Knowing your insurance benefits is your responsibility. Please contact your insurance plan with questions you may have regarding your coverage*****

This is an agreement between Joy Internal Medicine and the patient/responsible party signed below. By executing this agreement, you are agreeing to pay for all services that are received.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY AND AGREE TO ABIDE BY ITS GUIDELINE.

Patient's Name: _____

Patient's Signature: _____

Date: _____