WEST MICHIGAN FAMILY HEALTH

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Financial Policy

As family physicians, we take care of the entire family – men, women and children of all ages. The health and wellness of you, our patient, is top priority. Our goal is to provide comprehensive, compassionate, cost effective care to every patient regardless of age, gender, race or sexual orientation. We take that responsibility seriously and are constantly seeking ways to optimize your medical care. We also feel it is a responsible business policy to clearly communicate our financial expectations of you. If you have any questions regarding this financial policy, please do not hesitate to speak with our billing department or our office manager. We consider it a privilege that you have chosen West Michigan Family Health as your family's physician.

Payment for Services:

Payment for services is expected at time of service. If we do not participate with your health insurance plan, you are responsible for the full payment at the time of service. We participate with most insurance plans such as: Aetna, ASR (Physician's Care), Blue Cross Blue Shield, Blue Care Network, Cigna, Cofinity, Humana, Medicare, Medicare HMO's, Messa, Multiplan, Priority Health, Tricare, and United Healthcare. If you don't see your insurance plan listed, please contact your insurance carrier to verify our participation.

Your insurance plan requires that you present your insurance identification card(s) at each visit to ensure correct billing and eligibility information. If your insurance requires you to select a primary care physician, one of our physicians must be selected in order for you to be seen. If we are not provided with correct insurance information or cannot verify insurance coverage, payment will be expected in full at time of service. Co-pays, coinsurance and deductibles must be paid at the time of service. If your co-pay is not paid at time of service, we charge an additional $10 statement fee.

Everyone should obtain a summary of covered benefits from their insurance company. Please contact your insurance company with any questions you may have regarding your coverage or insurance payment issues. Services we provide may be non-covered by your insurance. Payment for service is ultimately your responsibility.

Methods of Payment:

We accept cash, check, money order and debit/credit cards including VISA, Mastercard and Discover Card. If a payment is made by check and it is returned due to insufficient funds or account closed, you will be charged $25. Future payments will be accepted in cash, money order or debit/credit cards only.

Nonpayment or Overdue Payments:

If you are not able to pay for services when provided, please notify the business office staff at 616-455-1176. If you are on a payment plan and cannot make your monthly payment, please contact our biller at 616-455-1176. If your account balance is over 90 days past due and no payment has been received, your account status will be pre-collections and you have 10 days to pay unless other arrangements (ie: payment plan) have been made. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency

and you and your immediate family members will be discharged from this practice. If you are discharged from our practice, our physicians will only be able to treat you on an emergency basis for 30 days.

Newborns:

It is essential that you enroll newborn infants with our insurance carrier within 30 days of the child's date of birth. If your child is not enrolled, the child has no insurance coverage under your policy. If you fail to do this within 30 days following the birth of your child, we will bill you directly for the services provided. Newborns have frequent office visits including immunizations which are costly. Please contact your insurance to find out if immunizations are covered prior to your office visit. If immunizations are not covered, your child may be eligible for free immunizations through the Vaccines for Children program.

Missed Appointments:

We request a 24 hour's notice for appointment cancellation. If you miss your appointment, we will charge a $50 no show fee which must be paid prior to your next appointment. Missed appointments interfere with our ability to provide the highest quality of care for all of our patients. Our no show policy states that after 3 no shows or missed appointments, your family will be discharged from our practice.

Forms for school, camp, sports, daycare, FMLA, disability, etc:

We require a $25 fee to fill out most forms (e.g., daycare, camp sports.) A $40 form fee is required for FMLA and short term disability forms. Form fees do not apply if an office visit is required to complete the form. All form fees must be paid before the form is completed and picked up or faxed. The form fee does not apply to any form that requires an office visit to complete, Priority Health HealthbyChoice Incentive forms, Blue Care Network HealthyBlue Living forms, or patient assistance forms.

Authorization for Medical Care:

Generally children under 18 are considered minors. Minors must be accompanied by a parent or legal guardian. If this is not possible, a written consent to treat form must be signed and dated by a parent or legal guardian. The parent or legal guardian accompanying a minor for services is responsible for any required payments at time of service (ie: co-pay, coinsurance, deductible).

I agree, in order for West Michigan Family Health to service my account or to collect any amounts I may owe, they may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. West Michigan Family Health can also contact me by sending text messages or emails, using any email address I provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

West Michigan Family Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Your signature below confirms you have read, understand and agree to our financial policy. A copy will be provided for your records.

_____

Printed patient name

_____

Patient (or guardian) signature

_____

Date signed