AVALON
MEDICAL GROUP

2400 E. Avalon Avenue, Muscle Shoals, AL 35661
256-386-0808

Patient Financial Policy

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, or your financial responsibility. If you need further assistance, contact our account representative: Rana Terry – 256-386-0808.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING DOCTOR. WE WILL ASK TO SEE YOUR INSURANCE CARD ON EVERY VISIT AND WILL SCAN YOUR INTO OUR SYSTEM AS NEEDED TO KEEP OUR INFORMATION CURRENT.

Minor Patients: Patients are financially responsible for care rendered to the minor child(ren). The adult (parent/guardian)accompanying the minor to the first visit is responsible for any balances not covered by the insurance plan. Minors not accompanied by an adult will be rescheduled if appointment is non-emergent. If the parent gives written permission to treat without a parent present and the charges have been pre-authorized for payment prior to treatment, then the minor can be treated.

Co-Payments: Your insurance REQUIRES that we collect your designated co-pay at the time of service. Please be prepared to pay at each visit.

Self-Pay: Self-Pay accounts shall exist if a patient has no insurance coverage. For new patients, a payment of $150.00 is expected at the day of your appointment before being seen by the health care provider. If you are unable to pay the $150.00, please contact our patient account representative prior to your appointment.

EXTENDED PAYMENT PLANS: Patients are encourage to pay outstanding self-pay balances in full. However, payment plans maybe accepted with the approval of the business office extending payments over six (6) month period. If you are unable to pay within six (6) months, arrangements with our patients accounts representative must be made.

REFFERALS: If your plan requires a referral from your primary care physician it is your responsibility to obtain it prior to your appointment and have it with you at the time of your appointment. **IF YOU DO NOT HAVE YOUR REFERRAL, YOU MAYBE REQUIRED TO RESCHEDULE.**

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ACCIDENT/WORKERS COMP CASES: Patients shall be financially responsible for medical services related to ACCIDENT/WORKERS COMP. It is the responsibility of the patient to notify Avalon Medical Group of date, injury, claim #, insurance company address, phone #, and contact person prior to first treatment of the injury.

MEDICARE: We will submit to Medicare for the Medicare allowed amount. The patient will be responsible for the deductible and the co-insurance, which can be billed to a secondary insurance if you have one.

RETURNED CHECK FEES: Any returned check from the bank for non-payment (insufficient funds) shall result in the patients account being assessed a fee of $30.00 per check returned. We reserve the right to require future payments made by credit card, money order, or cash.

AGREEMENT TO PAY & ACCEPTANCE OF PAYMENT POLICY

I, the undersigned, accept the fee(s) charged are due at the time of service. Should it become necessary to forward my account to collection, I agree to pay all monies due, including at 33.33% collection fee, Attorney fees, and/or Court Costs, if such be necessary. I waive now and forever, my right of exemption under the laws of the Constitution of the State of Alabama and any other state. I, the undersigned, give Avalon Medical Group, its employees and agents, express prior consent to contact me at any or all phone numbers, including cell numbers, for the purpose of treatment, insurance, and/or payment.

I have read this Financial Policy and agree to its terms.

Responsible Party Signature:_____ Date:_____
Print Patient Name:_____ Date:_____