East Valley
FAMILY
Physicians P.L.C.
Serving the Valley for Over 30 Years

East Valley Family Physicians

"Patient Responsibilities and Financial Policies"

Please read, sign and date the bottom

- It is the patient's responsibility to know your insurance benefits and policy requirements for office visits, procedures and vaccinations.
- It is the patient's responsibility to bring your current insurance cards(s) and method of payment to each office visit.
- It is the patient's responsibility to update your insurance information, current address and contact information for our records. Failure to do so will cause the patient to become responsible for all charges.
- It is the patient's responsibility to notify our office 24 hours prior to your scheduled appointment if you are unable to keep your appointment. Failure to do so will result in a $50 no show/cancelation fee which must be paid prior to scheduling your next appointment.
- It is the patient's responsibility to fully participate in decisions involving his/her own health care and to accept the consequences of those decisions.
- I understand and agree, to pay all copays, co-insurance, deductibles or "cash pay" estimated amounts at the time of service.
- I understand that a copy of my explanation of benefits (EOB) will be sent to me by my insurance company when my claims are processed.
- I understand it is my responsibility to pay all balances within 30 days after my insurance has paid their portion.
- I understand that if for any reason my insurance company does not pay for services within 90 days of the services being provided, I shall assume responsibility for the total amount owed.
- I understand if my account is not paid within 30 days from the date of my final billing statement that my account will be referred to a collection agency and I will be discharged from the practice.
- I understand that if I do not have my insurance card with me at my appointment that I will be required to pay, the current Self Pay office visit fee, up front.

I hereby authorize my insurance benefits to be paid directly to East Valley Family Physicians, realizing I am responsible to pay all non-covered services, which shall include all outside labs, x-rays, specialists or non-contracted facilities. If proper & current insurance information is not given, I will be responsible for all charges. I hereby authorize the release of pertinent medical information to insurance carriers. I understand if this account should become delinquent & referred to a collection agency, I will be responsible for any collections or legal fees.

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Patient Name (please print) Date of Birth

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Patient Signature (or parent/guardian if under 18) Date