



ASHLAND
FAMILY PRACTICE

Cindy Parks-Landis, FNP
Jennifer Moss, FNP
Anne Taylor, FNP
Sharon Scelza, FNP

935 SISKIYOU BLVD.
ASHLAND, OR 97520

(541) 482-2716

Financial Policies

Thank you for choosing Ashland Family Practice as your medical provider. We have written this policy to keep you informed of our current financial policies.

NO INSURANCE Payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make prior arrangements. When you pay in full at the time of service, we can offer you a "prompt pay" discount of 15%.

INSURANCE Although we are contracted with several insurance companies, it is your responsibility to make sure that our provider is in your plan. It is also your responsibility to know your insurance benefits and inform us of any changes in your insurance coverage. This ensures accurate billing and referrals. As a courtesy, we will bill up to two of your insurances. We cannot become involved in disputes with your carrier regarding your benefits.

Co-pays are due at the time of service. It is your responsibility to know the amount of your co-payment. The co-pay cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier.

For your convenience we accept cash, checks, debit cards, Visa, MasterCard, and money orders. Payments are also accepted over the phone.

AUTO ACCIDENT We will bill for motor vehicle accidents, but only as a courtesy. If your motor vehicle insurance carrier does not pay or does not pay in a timely manner, then payment in full is your responsibility. We will supply any information that may be needed for you to submit to your motor vehicle insurance.

LIABILITY INJURY If your injury is a result from another party's negligence, you are required to pay for services and then collect from the responsible party. We will not file your insurance, but will provide you with a receipt to do so.

WORKER'S COMPENSATION If your injury is due to an accident in your workplace, please inform the receptionist before you see the provider. It is your responsibility to know your employer's workers compensation insurance.

RETURNED CHECKS There is a \$35.00 return check fee on all returned checks.



ASHLAND
FAMILY PRACTICE

Cindy Parks-Landis, FNP
Jennifer Moss, FNP
Anne Taylor, FNP
Sharon Scelza, FNP

935 SISKIYOU BLVD.
ASHLAND, OR 97520

(541) 482-2716

BILLING

If you have any questions about your bill, please call us. The office is staffed Monday through Friday from 8:00 AM to 5:00 PM. The phone number is (541) 541.482.2716

COLLECTIONS

Accounts that are not paid within 30 days will begin our in-house collection process. If your balance is not paid monthly and in a timely manner, you may be subject to dismissal from the practice.

MEDICAL RECORDS

We will provide you a copy of your medical records upon request, one time for no charge. Any further copies will require a fee. You will need to sign a letter of release prior to having them copied. Please allow up to 30 days for this request to be processed.

NO SHOW POLICY

We understand that there are times when you must miss a doctor’s appointment due to emergencies or obligations for work or family. However, if you do not call to cancel an appointment at least 24 hours prior, you may be preventing another patient from getting much needed treatment and/or disrupting the providers’ schedule. We will allow a “one time” no show appointment. However, there will be a charge of \$50.00 for every appointment missed without at least 24 hours notice. Insurance will not cover this charge it will be the patient’s responsibility. Repeated missed appointments may result in your physician sending a letter discharging you from the practice. If this occurs, we will provide thirty days of urgent care only and transfer your medical records when you find a new physician.

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance benefits to be paid directly to the above signed physician, realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

ACKNOWLEDGMENT

I acknowledge that I have received and read a copy of the Ashland Family Practice financial policies.

Patient’s Name (Please Print) _____

_____ Date _____

Signature of Patient or Legal Representative