Thank you for choosing an office of the FCHC Medical Group as your health care provider. We are committed to your treatment. Please understand that payment of your bill is considered a part of your treatment. All patients must complete the required forms and are required to read and sign this Financial Policy prior to any treatment.

***Insurance Companies:*** We have contracts with most commonly used insurance companies. Please check to see if we accept your insurance. If we do not accept your insurance policy, as a courtesy, we will bill your insurance company. Your insurance policy is a contract between you and your insurance company. We are not a party of that contract. If we bill your insurance company and they have not paid your account in full within 45 days, the balance may be billed directly to you. Any subsequent visits must be paid in full at the time the services are rendered. Please be aware that some insurance companies, including Medicare, may determine treatment to be non-covered or find it not to be reasonable or necessary. If such a determination is made, you will be responsible for such services. Such services will be billed and payment is due upon receipt of bill.

***Regarding insurance plans where we are a participating provider:*** All co-pays and deductibles are due at the time of treatment. If there are any additional procedures performed, they may be subject to an additional **Co-Payment, Deductible or Co-Insurance.** Please refer to your HealthCare Plan for additional information. In the event that your insurance coverage changes to a plan where we are not a participating provider, refer to the above paragraph.

***Usual and customary rates:*** Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company’s arbitrary determination of what constitutes a usual and customary rate.

***Injury/Accidents:*** If you are being seen for an injury, please advise the office at the time of scheduling your appointment. Your insurance may require additional information.

***Minor patients:*** The adults accompanying a minor and the parents (or guardians of the minor) are responsible for payment. Unaccompanied minors presenting for non-emergency treatment will be denied if there is no authorization or consent to treat.

***Co-pays and Balances:*** Co-pays are due at the time of service. You will also be asked to pay any outstanding patient balance at the time of an appointment.

***Disability Form Fees:*** You may be charged a fee for completion of forms. Please complete the Patient portion of the form before submitting it to the office staff.

***Remitting Payment:***  Please remit payment to FCHC Medical Care, LLC at 735 S. Shoop Ave. Wauseon, OH 43567. For your convenience we accept cash, check, Visa, MasterCard and Discover.

***Insufficient Fund Fee:*** Checks that are returned will be charged a $30.00 insufficient funds fee.

Please let us know if you have any questions or concerns.

**I have read the *Financial Policy* and I understand and agree to its provisions.**

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Patient Name Patient DOB

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Signature of Patient or Guardian Date