

# Patient Agreement

Thank you for choosing Sound Family Medicine (SFM) as your care provider. We are committed to providing quality care to every patient in a courteous and professional manner. It is our hope that you understand SFM's credit and collection policies are a necessary part of assuring the financial resources required to maintain vital healthcare services for our patients.

## **Copayments and Deductibles**

Co-payments and deductibles are a part of a patient's insurance contract and are due at the time of service. SFM will collect co-payment or deposit towards deductible at the time of check-in for an appointment. If the patient is unable to pay co-pay, the patient will be required to reschedule the visit.

## **Billing for Services**

Sound Family Medicine charges for all services that are significant and separately identifiable. Patients who are seen for a preventative physical exam and receive treatment or evaluation of illness or chronic problems may be charged for each service even when both services are provided on the same day or at the same visit. SFM can only process charges for a patient's visit with a diagnosis that was encountered and documented in the medical record, by the provider. There may be a fee for any forms that are completed by, or require, a physician's signature or opinion.

## **Proof of Insurance**

To process medical claims accurately, we ask that patients bring insurance card(s) to each visit. If at any point there are changes in insurance coverage, patients are responsible for notifying and supplying SFM with the new insurance information and card. It is the patient's responsibility to understand their insurance policy and benefits.

## **Unpaid/Outstanding Balances**

All account balances billed are due upon receipt of the statement. Unpaid balances greater than 120 days are subject to our collection process, unless the patient contacts one of our account specialists to set up a formal payment plan within clinic guidelines. There will be a fee assessed for any returned forms of payment and checks. This fee will be applied to the patient's account in addition to the insufficient funds amount. If the patient is unable to pay past due balance, and does not have a current payment plan, the patient will not be eligible to be seen by one of our providers until the outstanding balance is paid in full and the payment has been cleared.

## **Missed Appointments**

Sound Family Medicine strives to provide excellent and comprehensive care for our patients. If a patient does not show up to their scheduled appointment, it impacts the provider's schedule and decreases other patients access to care. We ask patients to honor the time they have scheduled with their provider and have created our no-show policy to reduce the number of missed appointments.

**The Policy**

- In the event a patient does not arrive to one or two appointments, or is more than 15 minutes late, and the provider is unable to work the patient into their schedule, the patient will receive a warning letter reminding them of our no-show policy.
- After the third missed appointment, it is entirely up to the provider's discretion to place the patient on probation, initiate Discharge Policy, or excuse the third no show.

**Probation**

- Probation status restricts patients from scheduling future appointments for 12 months.
- Patients will only have access to same day appointments.
- If the patient is in good standing after the 1-year probation period, probation will be overturned.

**Patients are encouraged to call (253) 848-5951 if an appointment requires rescheduling.**

**I consent to medical treatment and have verified the insurance that I have provided is valid and authorize my insurance benefits to be paid directly to Sound Family Medicine. I authorize Sound Family Medicine to release any information required for processing of claims associated with services I receive at Sound Family Medicine. I understand that I am financially responsible for any balance due and have read and understand the above insurance/payment policy.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
(if not the patient)