PATIENT FINANCIAL RESPONSIBILITY ASSIGNMENT OF BENEFITS
Macomb Medical Clinic, P.C.

English Version:
Macomb Medical Clinic, P.C. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.
Spanish Version:
Macomb Medical Clinic, P.C. cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

This is an agreement between Macomb Medical Clinic, P.C., as Creditor and the patient/Debtor named on this form. In this agreement the words "you" and "yours" means the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us" and "our" refer to Macomb Medical Clinic, P.C. By executing this agreement, you are agreeing to pay for all services that are received.

INSURANCE:

Insurance is a contract between you and your insurance company. We are **NOT** a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance preauthorization; you are responsible for obtaining it.

MONTHLY STATEMENTS/PAYMENTS:

The balance on your statement is due and payable when the statement is issued, and the past due if not paid within 30 days of a statement date. A late fee will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. If your account becomes past due we will take necessary steps to collect this debt. If we refer your account to our collection agency, you agree to pay all of the collection, court costs and lawyer fees which are incurred. All deductibles, co-pays and self-pay accounts are due and payable at the time of service. A Five Dollar **($5.00)** statement processing fee will be charged for non-payment of co-pays not paid at the time of service.

RETURNED CHECKS:

There is a fee **(Currently $35.00)** for any checks returned by the bank.

CANCELLED/RESCHEDULED/ MISSED APPOINTMENTS:

Patients are expected to call the office to cancel or reschedule their appointment **by 2:00 p.m. the day prior to their scheduled appointment** to notify us of any changes or cancellations. **To cancel or reschedule a** *Monday* **appointment, they should call by 2:00 p.m. the** *Friday before.* **Appointments following a holiday should be cancelled by 2:00 p.m. the last business day before the holiday.**

There will be a ***$90.00 charge*** for no show appointments without a 24 hour notice for all "***Wellness Exams and Pap Smears",*** and a ***$50.00 charge*** for ***"all other"*** no show appointments and cancelled appointments without 24 hour notice.

Patients who call after 2:00 p.m. will be considered a "less than 24 –hour notice cancellation".

- **Fees:** A fee of ***$50.00 dollars*** is charged for cancelled or rescheduled appointments after the cut off time.
- **The first Cancelled/Rescheduled appointment: "Less than 24 hour-notice cancellation"** status is entered into the patient's record, as a courtesy the patient will be notified via call, text or mail and reminded of the Cancellation/Reschedule policy and the fee will be waived. A note will also be entered in the patients' EMR.
- **The second Cancelled/Rescheduled appointment:** The **"less than 24-hour notice cancellation"** status is again entered in the patient's record and a Cancelled/Rescheduled fee is charged without notice to the patient. A note will also be entered in the patients' EMR.
- **Pattern of Cancelled/Rescheduled appointments:** A patient who has cancelled and/or rescheduled three appointments past the 2:00 p.m. cut off time in a 12-month period or less may be asked to leave the practice. Exceptions may be made for children.

RESCHEDULED APPOINTMENTS:

Rescheduled appointments will require that all fees are paid in full before the patient is seen by the physician.

EXCEPTIONS:

Fees may be waived for situations of inclement weather, catastrophic circumstances and emergencies (subject to the office manager's approval).

FORMS:

Due to the rising costs associated with HIPAA compliance & regulations, it has become necessary to charge a fee for the completion of certain forms and correspondence. The fees range from $10.00 - $150.00. These fees must be paid in full before the document can be picked up, mailed or faxed.

EFFECTIVE DATE:

Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force.

Patients Name (print)**:**_____ **Date of Birth:** ____/____/_____

Signature: _____**Date:**_____

Responsible Party (If Patient is a Minor) _____**Relationship:**_____