OLIVE BRANCH
FAMILY MEDICAL CENTER

THIS FORM MUST BE COMPLETED IN FULL

PATIENT INFORMATION

PLEASE PRINT

Patient Name (Last, First, MI) _____ Age _____ Marital Status M ❑ S ❑ D ❑ W ❑

Address _____ City / State _____ Zip _____

Home Phone _____ DOB ____ / ____ / ____ Sex: M / F Soc. Sec. # _____ - _____ - _____

Occupation _____ Employer Name _____

Address _____ City _____ St ____ Zip _____ Phone _____ Ext _____

Name of Spouse or Parent _____ DOB ____ / ____ / ____ SS# _____

Address _____ City _____ St ____ Zip _____ Phone _____ Ext _____

Email address if known: _____ Referred by: ❑ Friend ❑ MD ❑ Phone Book ❑ Other

RESPONSIBLE PARTY / GUARANTOR

Responsible Party's Relationship to Patient ❑ Self ❑ Spouse ❑ Child ❑ Other _____ Responsible Party's Date of Birth ____ / ____ / ____

Responsible Party's Name (Last, First, MI) _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ SS# _____

Employer _____ Address _____

Responsible Party's Spouse's Name _____ DOB ____ / ____ / ____ Work Phone _____

INSURANCE INFORMATION

Insurance Company _____ I.D. Number _____ Group # _____

Relationship to Cardholder Self ❑ Spouse ❑ Child ❑ Other ❑ _____ Cardholder's DOB ____ / ____ / ____

Cardholder's Name _____ Cardholder's Address _____

City _____ St _____ Zip _____ Cardholder's Home Phone _____

Cardholder's Employer _____ Cardholder's Work Phone _____ SS# _____

What hospital are you required to use? _____

PERSON TO CONTACT IN CASE OF EMERGENCY - MUST COMPLETE THIS SECTION

Name _____ Phone _____

Address _____ Realtionship _____

I understand that OLIVE BRANCH FAMILY MEDICAL CENTER is not a provider for MS Medicaid or TennCare. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including all private insurance and other health plans to OBFMC. This assignment will remain in effect until revoke by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize assignee to release all information to secure payment. I understand that I am financially responsible for all charges whether or not paid by insurance. I agree to pay interest on any past due monthly account balance. Should my account be placed with a collection agency or referred to an attorney for purposes of seeking judicial relief, I agree to pay all costs of collection, reasonable attorney's fees, expenses, all costs of court, plus pre and post-judgment interest on any judgment. PAYMENT IS DUE AT TIME OF SERVICE.

_____

SIGNATURE OF PATIENT/GUARDIAN DATE

Olive Branch Family Medical Center
9075 Sandidge Center Cove
Olive Branch, MS 38654-3514
Phone (662)895-4949
Fax (662)895-6776
www.obfmc.com

Please initial each and sign at the bottom.

AUTHORIZATION TO DISCLOSE PHI

I hereby authorize OBFMC to leave a message and/or discuss my protected health information (PHI), to include account information, test results, scheduled appointments, and information regarding my healthcare with the following people:

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Please note: Any person that is not listed above will not be able to obtain any information regarding your PHI from this office. Insurance companies and other physician offices do not need to be listed.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ I have been notified of Olive Branch Family Medical Center's Notice of Privacy Practices and been offered a copy of these documents.

CONSENT FOR CARE

_____ I hereby give my consent for treatment to OBFMC. If patient is a minor, authorization will remain in effect until the age of 18 or until written notice is given to OBFMC from guardian.

RECEIPT OF COLLECTION POLICY

_____ I have been notified of Olive Branch Family Medical's Credit and Collection policy and been offered a copy of these documents.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND FILE MEDICARE/COMMERCIAL INSURANCE CLAIMS

I authorize OBFMC to file claims to and collect payments from my insurance company for services rendered to me or my dependents until such agreement is terminated in writing. I also authorize the release of any information necessary for claim payments. I understand that I am responsible for balances that are not covered by my insurance, co-pays, deductibles, and co-insurance amounts required by my insurance. Collection costs and legal fees incurred in order to collect a balance owed is the responsibility of the patient and/or responsible party.

Signature:_____ _____ Date:_____
Patient, Parent, or Guardian Relationship

Patient Name _____ Date of Birth _____

Olive Branch Family Medical Center
9075 Sandidge Center Cove
Olive Branch, MS 38654
Phone (662)895-4949
Fax (662)895-6776

AUTHORIZATION FOR RELEASE OF INFORMATION

Please complete One Form for each physician that you see.

I hereby authorize disclosure of my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by federal privacy regulations.

Today's Date: _____

Patient Name: _____ SSN:_____ DOB:_____

Person/Organization providing information	Person/Organization receiving information *If sending to OBFMC, check here:*
Name _____	_____
Address_____	_____
_____	_____
Phone _____	_____
Fax _____	_____

Release: Complete Records Lab Results Only Progress Notes Only

Other (specify): _____

If you do not want certain portions of your medical record released, please read this section carefully and initial the boxes for the information you do not want released. Otherwise, your records will be released as specified above. I authorize the health care provider to release the information specified to the organization, agency, or individual named above with the exception of:

Substance abuse AIDS/HIV Psychological or psychiatric conditions

Other (specify): _____

I understand that I have the right to revoke this authorization at any time by presenting my written revocation to OBFMC. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If this authorization has not been revoked, it will terminate on the following date, even or condition:

_____ If I fail to specify an expiration date, event or condition, this authorization will automatically expire in 12 months.

Signature of Patient or Personal Representative Printed Name of Patient or Personal Representative

If Personal Representative, the patient is unable to sign because: Minor Incompetent

Other (explain): _____

Olive Branch Family Medical Center
Notice of Privacy Practices

Effective Date: January 3, 2012
This Notice was last revised on July 10, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER(S):

HIPPA Privacy Officer:	**Amy Green**	**662-893-8484**	**agreen@obfmc.com**
Systems Security Officer:	**Faith Wilson**	**662-895-4949**	**fwilson@obfmc.com**
Office Address:	**9075 Sandidge Center Cv.**		
	Olive Branch, MS 38654		
Fax:	**662-895-6776**		

About This Notice
We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information, your right to receive – and our obligation to provide – notice if there is a breach of your unsecured protected health information. This Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information?
Protected Health Information is information that individually identifies you and that we create or get from you or from another health care provider, a health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your Protected Health Information

We may use and disclose your Protected Health Information in the following circumstances:

For Treatment. We may use Protected Health Information to give you medical treatment or services and to manage and coordinate your medical care. For example, we may disclose Protected Health Information to doctors, nurses, technicians, or other personnel who are involved in taking care of you, including people outside our practice, such as referring or specialist physicians.

For Payment. We may use and disclose Protected Health Information so that we can bill for the treatment and services you get from us and can collect payment from you, an insurance company, or another third party. For example, to obtain payment from your health plan for health care services and items, we may need to give your health plan information about your treatment or to obtain pre-authorization to find out if your plan will cover the treatment. If a bill is overdue we may need to give Protected Health Information to a collection agency to the extent necessary to help collect the bill, and we may disclose an outstanding debt to credit reporting agencies.

For Health Care Operations. We may use and disclose Protected Health Information for our health care operations. For example, we may use Protected Health Information for our general business management activities, for checking on the performance of our staff in caring for you, for our cost-management activities, for audits, or to get legal services. We may give Protected Health Information to other health care entities for their health care operations, for example, to your health insurer for its quality review purposes.

Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services. We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

Minors. We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

Personal Representative. If you have a personal representative, such as a legal guardian (or an executor or administrator of your estate after your death), we will treat that person as if that person is you with respect to disclosures of your Protected Health Information.

Research. We may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been specially approved by an institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researchers to look at Protected Health Information to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any Protected Health Information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. But we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the security of the data, and (3) not identify the information or use it to contact any individual.

As Required by Law. We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclosure the information to someone who may be able to help prevent the threat.

Business Associates. We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy of your Protected Health Information.

Organ and Tissue Donation. If you are an organ or tissue donor, we may use or disclose your Protected Health Information to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Protected Health Information as required by military command authorities. We also may release Protected Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may use or disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Protected Health Information for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and (8) the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

Health Oversight Activities. We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves if you sue us.

Law Enforcement. We may release Protected Health Information if asked by a law enforcement official for the following reasons: in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if; about a death we believe may be the result of criminal conduct; about criminal conduct on our premises; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

National Security. We may release Protected Health Information to authorized federal officials for national security activities authorized by law. For example, we may disclose Protected Health Information to those officials so they may protect the President.

Coroners, Medical Examiners, and Funeral Directors. We may release Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide

you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

Individuals Involved in Your Care or Payment for Your Care. We may disclose Protected Health Information to a person who is involved in your medical care or helps pay for your care, such as a family member or friend, to the extent it is relevant to that person's involvement in your care or payment related to your care. But before we do that, we will provide you with an opportunity to object to and opt out of such a disclosure whenever we practicably can do so.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

Your Written Authorization is Required for Other Uses and Disclosures. Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation. Examples of circumstances where your authorization is required include:

- for communications that market a health related product or service that encourage you to purchase or use a product or service and we receive direct or indirect payment for that communication;
- under most circumstances, without your written authorization we may not disclose the psychotherapy notes a mental health professional took during a private counseling session; and
- a sale of your protected health information.

Special Protections for HIV, Alcohol and Substance Abuse, Mental Health, and Genetic Information. Special privacy protections apply to HIV-related information, alcohol and substance abuse, mental health, and genetic information. Some parts of this general Notice of Privacy Practices may not apply to these kinds of Protected Health Information. Please check with our Privacy Officer for information about the special protections that do apply. For example, if we give you a test to determine if you have been exposed to HIV, we will not disclose the fact that you have taken the test to anyone without your written consent unless otherwise required by law.

Your Rights Regarding Your Protected Health Information. You have the following rights, subject to certain limitations, regarding your Protected Health Information:

Right to Inspect and Copy. You have the right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for your care. But you do not have a right to inspect or copy psychotherapy notes. We may charge you a fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed health care professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Security Breach. We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breach of your Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days after we discover the breach. "Unsecured Protected Health Information" is Protected Health Information that has not been made unusable, unreadable, and undecipherable to unauthorized users. The notice will give you the following information: a short description of what happened, the date of the breach and the date it was discovered; the steps you should take to protect yourself from potential harm from the breach; the steps we are taking to investigate the breach, mitigate losses, and protect against further breaches; and contact information where you can ask questions and get additional information. If the breach involves 10 or more patients whose contact information is out of date we will post a notice of the breach on our website or in a major print or broadcast media.

Right to Request Amendments. If you feel that Protected Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. We may deny your request if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) was not created by us, (2) is not part of the medical information kept by or for us, (3) is not information that you would be permitted to inspect and copy, or (2) is accurate and complete. If we deny your request, you may submit a written statement of disagreement of reasonable length. Your statement of disagreement will be included in your medical record, but we may also include a rebuttal statement.

Right to an Accounting of Disclosures. You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your Protected Health Information. We are not required to list certain disclosures, including (1) disclosures made for treatment, payment, and health care operations purposes, (unless the disclosures were made through an electronic medical record, in which case you have the right to request an accounting of those disclosures that were made during the 3 years before your request), (2) disclosures made with your authorization, (3) disclosures made to create a limited data set, and (4) disclosures made directly to you. You must submit your request in writing to our Privacy Officer. Your request must state a time period which may not be longer than 6 years before your request. Your request should indicate in what form you would like the accounting (for example, on paper or by e-mail). The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we agree, we will comply with your request unless we terminate our agreement or the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a special address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time. You can get a copy of this Notice at our website: www.obfmc.com.

How to Exercise Your Rights
To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes to This Notice
The effective date of the Notice is stated at the beginning. We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the United States Department of Health and Human Services. To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint. To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.

Optional Provisions to be included as applicable:

Foreign Language Version. If you have difficulty reading or understanding English, you may request a copy of this Notice in Spanish. If you require other language translation, please notify our front desk or Privacy Officer.

Medical Residents and Medical Students. Medical residents or medical students may observe or participate in your treatment or use your Protected Health Information to assist in their training. You have the right to refuse to be examined, observed, or treated by medical residents or medical students.
Newsletters and Other Communications. We may use your Protected Health Information to communicate to you by newsletters, mailings, or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our practice is participating.

Olive Branch Family Medical Center

CREDIT AND COLLECTION POLICY

This is an agreement between Olive Branch Family Medical Center, as the creditor and the patient/guarantor as debtor.

CREDITS: All credit balances are researched and refunded on a monthly basis, unless otherwise requested by the patient and/or guarantor. If, however, future visits have been established, Olive Branch Family Medical Center reserves the right to hold the credit and transfer it to an existing open account.
CO-PAYS: All co-pays are due upon check-in. A $100.00 deposit will be collected at check in for all deductibles. Co-insurances and deductibles are to be paid in full upon check out.
INSURANCE: Any and all medical claims will be submitted to the appropriate insurance carrier, unless otherwise specified by the patient/guarantor. This is a contract between the subscriber/patient and the carrier. Verification of coverage will be established when the insurance company processes the claim.
PRIVATE PAY (NO INSURANCE): If the patient does not possess insurance coverage, there will be a $75.00 deposit collected upon check in. The balance for services rendered is due upon check out. If payment in full is not feasible, the patient/guarantor should contact the billing department prior to services being rendered to make appropriate arrangements on the account. All non-insurance patients will be given a 20% discount if payment in full is made at the time of service.
PRIVATE PAY (WITH INSURANCE): Any and all private pay balances, that are due after the insurance carrier has processed and paid their portion, is due in full upon receipt of statement. If payment in full is not feasible, the patient/guarantor is responsible for contacting the billing department to make appropriate payment arrangements. PROMPT PAYMENT LAW: Due to the Prompt Payment Law established by the State of MS, if a claim has been received and verified as "clean", the insurance carrier has 45 days to process and pay the medical claim. If the claim is not processed and paid in the allotted timeframe, Olive Branch Family Medical Center reserves the right, in accordance with the law, to transfer the responsibility for payment to the subscriber.
WORKER'S COMPENSATION: Any and all Workers Compensation services are the responsibility of the patient/guarantor. Olive Branch Family Medical Center will file the medical claims as a courtesy, unless otherwise specified. All required information must be presented to the clinic prior to the initial visit.
PERSONAL INJURY: Olive Branch Family Medical Center does not file third party insurance. All patients involved in a motor vehicle accident will be responsible for payment at time of service. We cannot file your medical insurance on motor vehicle accident claims if there is a third party insurance involved.
RESPONSIBILITY OF ACCOUNT: All services rendered are the responsibility of the guarantor lited on the account. The guarantor of a minor should be the parent/guardian that brings the child in for services a majority of the time. If a child is covered under a parent's insurance policy and is over the age of 18, the child is responsible' for any and all outstanding balances.
PAYMENT PLAN OPTIONS: If payment in full is not feasible, an appropriate payment plan will be established with the billing department. Payment plans can be approved that require a monthly payment of the greater of $50.00 or 33.33% of the account balance, unless other arrangements have been made.
PAYMENT OPTIONS: Payment on an account can be made in the following form:

a. Cash b. Check c. Money Order d. Credit/Debit Card —VS, MC, DC, AMEX

STATEMENTS: Any and all accounts with a patient balance will receive a billing statement every 30 days indicating the amount due on the account. The billing department phone number will be shown on the statements should payment arrangements be necessary.
PAST DUE ACCOUNTS: An account will be considered past due if a payment has not been recorded within 45 days. The patient/guarantor will receive a written notice informing them of the outstanding balance along with the billing department's phone number so they may call to arrange a payment. All accounts are subject to further collection action if payments on the account are not being made on a regular basis. Payment no less than 33.33% of balance due on account will be expected before any further visits are permitted. Failure to pay account balance can lead to dismissal of the patient from the practice.
COLLECTION AGENCY: Once an account has been turned over to a collection agency, it becomes the sole responsibility of the collection agency. Any and all correspondence will need to be directed to the collection agency. RETURNED CHECKS: Accounts will be charged a $40.00 fee for any and all returned checks. These fees must be paid in full by Cash or Credit Card prior to any additional visits.