



PATIENT INFORMATION AND FINANCIAL AGREEMENT

Patient Name: _____ Date: _____
 Last Name First Name Middle Initial
 Home Address: _____ City State Zip
 Street
 Home Phone: _____ Work Phone: _____ Cell Phone: _____
 Date of Birth: _____ Social Security No.: _____ Sex: Male Female
 Marital Status: Single Married Separated Divorced Widowed
 Employer: _____ Phone: _____
 Address: _____

RESPONSIBLE PARTY (OR INSURED) INFORMATION

Patient Relationship to Responsible Party: Self Spouse Child Other: _____
 Name: _____
 Last Name First Name Middle Initial
 Home Address: _____ City State Zip
 Street
 Home Phone: _____ Work Phone: _____ Cell Phone: _____
 Primary Insurance Company: _____ Group No: _____
 Subscriber Name: _____ Subscriber ID No.: _____
 Secondary Insurance Company: _____ Group No: _____
 Subscriber Name: _____ Subscriber ID No.: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____
 Address: _____
 Home Phone: _____ Work Phone: _____ Other Phone: _____

FINANCIAL POLICY AND AGREEMENT

INSURED PATIENTS

- Patients are responsible for their own bill.** Insurance policies are a contract between patients and insurance companies. Foothill Family Clinic (FFC) is not a party to that contract.
- As a service to our patients, FFC will bill insurance companies we contract with if you have provided us complete information and/or a copy of your insurance card(s). **Note: Insurance cards must be presented at each visit.**
- We do not bill automobile insurance companies.** Visits relating to auto accidents are considered self-pay and payment in full is due at the time of service. FFC will provide the necessary information to submit to your auto insurance for payment.
- Co-payments are due at the time of service** — this is a requirement of your contract with your insurance company. A \$20 billing fee will be assessed if co-payments are not made at the time of service.
- Patients are responsible for all deductible amounts and charges not covered by insurance. Questions concerning non-payment of services should be directed to your insurance company.
- It is the responsibility of the patient to determine if specialists to whom they are referred are participating with their insurance plan.
- Insurance companies may require additional co-payment amounts for evening and/or weekend urgent medical care or walk-in care. This amount is due at the time of service.
- Some laboratory services provided to you are preformed at outside laboratories. Charges for these services may be billed to you directly by the outside lab. This bill is separate from charges billed by FFC. You are responsible for payment of outside charges to the lab performing the testing.

SELF PAYING PATIENTS — Payment in full is due at the time of service.

NO SHOW FEE: Appointments must be canceled at least 24 hours in advance, except for same day appointments which need to be cancelled as soon as possible. A fee of \$75 will be charged for physical exam and procedure no shows. \$25 will be charged for normal office visit/same day no shows.

PAST DUE ACCOUNTS: Personal balances over 30 days will be charged interest of 1½% per month (18% annual rate). If the balance is not paid as agreed, a 35% collection fee and any legal costs associated with collecting the balance will be charged.

PATIENTS UNDER CONTRACT: A \$20 fee will be assessed if payments are not received by the due date on the contract. Patients under contract must pay in full for all new uninsured services at the time of service.

I certify that all information provided is correct. I have read all information and policies and am duly authorized to execute this agreement and agree to all terms and conditions.

Signed: _____ Date: _____ DOB: _____
 (Patient, Parent or Guardian)