Patient Financial Agreement Form

Patient Name:____

I consent that I am responsible for (any and all) charges assigned to me by my insurance company including, but not limited to, yearly deductibles, co-insurances, co-pays, non-plan coverage, etc. __________________(Patient/Guardian Initials)*

Certain insurance companies and/or policies do not cover recommended care which may include vaccinations, lab work and other procedures and services. These services, if not covered by your insurance plan, will become your financial responsibility. ______________________(Patient/Guardian Initials)*

I consent that I do understand and will abide by the below listed administrative fees which are enforced by Woodstock Primary Care. I agree to pay for fees accordingly. _____________________(Patient/Guardian Initials)*

Administrative Fees

1)	Appointments cancelled with less than 24 hour notice=	$30.00
2)	Patient "NO SHOWS" for appointments=	$40.00
3)	Returned payment for Non Sufficient Funds=	$35.00
4)	Patient account placed with collection agency=	$45.00
5)	Request for release of medical records (paper/electronic)=	$25.00
6)	If patient account is unpaid for greater than 90days, a 6.5% interest charge will be applied to unpaid total owed.	% of Bill
7)	Completion of all patient requested forms, to include, but not limited to letters or any information requiring the Physician's signature, which includes other miscellaneous or administrative forms required by third parties, not your insurance company.	$40.00
8)	Family Medical Leave Act	$25

***Signature:**____ **Date:**_____________

Note: *= Patient understands Financial Requirements.

WOODSTOCK PRIMARY CARE
Appointment Cancellation Policy

Your appointment time is important to you, your physician, and to others who are in need of our services.

If you cannot keep your appointment for any reason, please call us as soon as possible prior to your appointment time. If you do not show for your appointment or do not cancel, **a fee of $40 will be charged to your account.** You will be personally responsible for this charge. This charge will not be billed to nor paid for by your insurance company. Future appointments will not be scheduled until this fee is paid.

You will receive an appointment reminder card at your visit with the date and time for your next visit.

Please help up keep the scheduling of appointments fair for everyone.

Thank you.

____________________________________ _______________
Patient/Parent Signature Date