Health, Travel, Immunizations,
and Physicals

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Patient Financial Agreement

Please review the following financial information at our office.

This document is a breakdown of Health Travel, Immunizations, and Physicals financial policies and an explanation of potential charges you could owe related to services at our office. Actual amounts vary depending on the type of service provided and your health insurance coverage at the time of service. This list is not comprehensive and may be updated without prior notice.

Type	Description	Amount
Co-payment/ Co-Insurance	Amounts vary based on insurance coverage and must be 1nade at the time of service.	Variable; based on insurance coverage.
Deductible	Patient is responsible for a certain amount of their health care expenses prior to insurance coverage paying for services. Amounts vary based on insurance coverage and must be made at the time of service	Variable; based on insurance coverage.
Phone Appointments	For medical care provided over the phone, in place of an in-person appointment.	Billed as an in-office appointment.
Missed Appointments	Missed appointments or appointments that are cancelled on the same date of the appointment.	$25
Blood Draws	Payment for specimen collection and processing. Additional charges from our laboratory may apply and be billed directly from the laboratory	$10
Completed Forms	Charge for form completion outside of a regular office visit or appointment.	$10 and up
Return Checks	Payment for specimen collection and processing. Additional charges from our laboratory may apply and be billed directly from the laboratory	$30
Late Fees	Non-payment of total balance in full at the time of service without prior approval from Family Care.	$10 initially+ $10 for three months of non-payment.
Records Requests	Printed or electronic copies of patient's medical records.	Variable; $30 max; $10 min; based on quantity requested.
Vaccinations	Vaccine administration.	Variable; based on vaccine.
Laboratory Fees	Billed directly from our contracted laboratories.	Variable; based on service.

I have read, understand, and agree with the above patient policy.

Signature ____ Date ____________________