

Martha Jefferson Medical Group

Financial Policy

Martha Jefferson Medical Group (MJMG) is committed to providing each patient with the best possible medical care. If a patient has special needs, we are here to assist in any way we can. The following information is provided to avoid any misunderstanding concerning payment for the professional services rendered by our practice.

For your convenience, we accept all of the following methods of payment:

- 1.) Cash
- 2.) Check
 - a. Effective 2-1-09 returned checks are subject to a \$35.00 fee
- 3.) Visa
- 4.) Master Card
- 5.) Discover
- 6.) American Express
- 7.) Debit Card
- 8.) Travelers Check (with photo identification)

Full payment is due at the time of service unless we participate with your insurance company. Any required co-pays or deductibles owed by you will be collected at the time of service (a \$10.00 statement processing fee will be assessed to an account if payment is not made at time of service). If you are unable to pay your account balance in full, please ask the receptionist for payment options. You will be responsible to pay any billed amounts upon receipt of a statement from our billing office, unless other arrangements have been made. If your insurance plan determines a service not to be covered, we will bill you for that charge.

If we do not have a contract with your insurance carrier, we cannot accept assignment to be reimbursed by your carrier. In this case, charges would be due and payable by you at the time of service. As a courtesy we will however, bill your insurance plan on your behalf for any service we provide.

MJMG requests 24 hours advance cancellation notice for all appointments. If a patient does not contact the office in advance, a \$25.00 "No Show" fee may be charged for each appointment missed, depending on the circumstance of the cancellation. If a patient misses more than three (3) appointments in one year, MJMG reserves the right to discharge the patient, and ask the patient to seek medical care with another provider.

I agree to the terms of the Financial Policy:

Signature of Patient and/or Legal Guardian

Dates: