

Lifetime Family Care, a Division of Michigan Healthcare Professionals, P.C.

Financial Acknowledgement

Billing Office (586) 751-1177 Fax: (586) 751-1180

We are committed to providing you the best possible care. In order to better serve you, please read and familiarize yourself with our financial policies so that misunderstandings regarding our billing can be avoided. If you have any questions, please do not hesitate to call our billing office.

- You are in-network / out-of-network with our physician. If you would like a copy of the benefits we verified please ask the receptionist.
- If you are on an insurance plan that requires a referral, it is **your responsibility** to obtain that referral from your primary care physician and bring it with you to your visit. If no referral is obtained, you may be financially responsible for the costs of your visit in its entirety.
- Lifetime Family Care does not file insurance claims to insurance companies with which it does not have a contractual relationship. If we are out-of-network with your insurance, you will be required to **pay in full at the time of service** and submit a claim to your insurance company. If your physician is out of network with your insurance, your payment (which may range from \$100 to \$500) is **due at time of service**.
- At your request, we will provide an estimate of today's services. If you are requesting an estimate of charges for future services it may result in a delay in scheduling and provision of the services. Estimates will be provided no later than 10 business days after the request is made. We have 10 business days after the date on which the estimate was requested.
- We have a returned check fee of \$35.00 that will be assessed on all checks not paid by your bank for any reason.
- At any time if you do not understand your statement we shall provide, in plain language, a detailed explanation of the charges for services or supplies previously made on a bill or statement.
- It is the policy of the Practice to monitor and manage appointments. A patient who **fails to arrive** for a scheduled appointment without **canceling** the appointment less than **24 hours prior** to the scheduled time, **OR** a patient who fails to arrive for a scheduled appointment, is considered a "**NO SHOW**". The charge for a no-show patient is \$25, as set by the Practice. **You**, not your insurance company, will be billed this amount and it will be reflected on your statement.
- If you are aware of any overpayment, please feel free to contact our billing office.
- All form fees are due at time of pick up.
- If we are required to send multiple statements to collect a balance, you will be responsible for statement fees.

I have read, understand, and acknowledge the Financial Policy of Lifetime Family Care, A Division of Michigan Healthcare Professionals, P.C.

Print Patient Name _____

Signature of Acknowledging Party _____

Date _____