SIERRA CARE PHYSICIANS

SIERRA CARE PHYSICIANS FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to providing quality care and service to all of our patients. Your clear understanding of our financial policy is important to our professional relationship. We ask that you read and acknowledge your understanding of this form.

I understand you will bill my medical insurance as a courtesy. I understand it is my responsibility to know and understand the exclusions and limitations of my insurance policy as we see patients with many types of insurance plans which makes it impossible for us to know all the covered benefits. It is your responsibility to provide us correct insurance information at the time of service including any secondary insurance.

I will pay my co-payment at the time of service. Co-insurance and deductibles and non-covered services are due when my first statement is received, generally 30 days. This financial responsibility also applies if your insurance carrier is not contracted with Sierra Care Physicians. Sierra Care Physicians will bill non-contracted insurances (1) time as a courtesy to you, however, the patient is responsible for all charges and must pay any charges not paid by the non-contracted insurance.

Statements: We send statements out to the guarantor of the account. When you receive a statement from our office, your balance is due upon receipt of the statement. You may send your payment by mail or by calling our billing office at 530-272-9788.

Forms of Payment: We accept cash, check, Visa, Mastercard, Discover Card and American Express. Checks should be made payable to Sierra Care Physicians. ***A $25.00 fee will be charge for all returned checks.***

Collections Procedure: If your account is ninety (90) days or older you will receive a certified letter stating you have fifteen (15) days to pay your account in full. At this point partial payments will need to be negotiated with the billing department. Please be aware if your balance remains to be unpaid after receipt of the certified letter, your account will be sent to an outside collection agency which can affect your credit rating. In addition, you may be subject to discharge from the practice. You also agree that you will be liable for any attorney fees and costs in the event of an unpaid balance being sent to collections that are deemed necessary by Sierra Care Physicians.

No Show Fee: We ask that you give us a twenty-four (24) hour notice if you are unable to keep your appointment. Failure to give less than four (4) hour notice may result in a ***No-Show Fee of $40.00.***

By signing this form, I acknowledge the financial responsibility outlined in this document and that I have received a copy of said document.

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Signature/Print Account Guarantor/ Responsible Party **Date**