FAMILY HEALTH ASSOCIATES, LLC
1500 South 48th Street, Suite 412
Lincoln, NE 68506
Phone 402- 489-4600

FINANCIAL POLICY

Thank you for choosing F AMIL Y HEALTH ASSOCIATES, LLC as your health care provider. We are committed to your treatment success. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy. We require you to read and sign this prior to treatment. In addition, you will be asked to complete our registration and insurance form before seeing the doctor.

CO-PAYMENT AND DEDUCTIBLE AMOUNTS ARE DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, ATM CARDS, OR VISA, MASTERCARD AND DISCOVER CARD.

REGARDING INSURANCE

You are responsible for knowing the specific details of your insurance. This includes required hospitals, doctors on your plan, referral requirements, and pre-certification. We will not be responsible for sending you to an incorrect facility. As a courtesy, we will file claims to your insurance company for you. We cannot bill your insurance company unless you provide us with your current insurance information. **Please keep us updated with any insurance changes.** After we receive a response from your insurance company, we will send you a statementofyour financial responsibility to FAMILY HEALTH ASSOCIATES, LLC. **PAYMENT IN FULL is due upon the receipt of this statement unless alternative arrangements are made with our billing office. After 60 days past due, a $5.00 rebilling fee will be assessed each time a new statement is sent out.**

USUAL AND CUSTOMARYRATES

Our practice is committed to providing the best treatment for our patients and we charge rates which are usual and customary for similar services in our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

PAYMENT

Payment is expected at the time of service for those with an insurance deductible and/or co-payment. We will file your claim with your insurance company and refund any over-payment to you. Payments are expected at the time of service for those without insurance unless prior arrangements have beer! made with the billing office. Payment is also expected at the tim~ of service for those involved in a motor vehicle accident claim. **There may be a charge for any forms we must complete.** Any services not covered by your insurance company will be your responsibility.

MINOR PATIENTS

All minor patients will be treated with the consent of a parent or guardian, except in the case of an emergency.

MISSED APPOINTMENTS

We appreciate 24 hours notice to cancel an appointment. We understand there are circumstances where this is not possible. Any appointment cancelled within one hour prior to the appointment time will be treated as a missed appointment. Two missed appointments in two years may result in the termination of the care for you and/or your family. We reserve the right to charge for a missed appointment if not notified in advance.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns regarding this information.

I understand and agree to the financial policy of FAMILY HEALTH ASSOCIATES, LLC.

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PATIENT/LEGAL GUARDIAN SIGNATURE PATIENT NAME (PRINTED)

DATE_____