Patient Financial Policy

Thank you for choosing Galichia Medical Group as your health care provider. Our primary mission is to provide our patients with outstanding medical care. We are committed to providing state of the art treatment for all of your health care needs. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Carefully review the following information and return this form with your signature and today's date. Please ask if you have any questions about our fees, our policies and / or your responsibilities.

We request all patients complete our Patient Information Form prior to seeing the provider. Please notify our office of any patient information changes (i.e. address, name, insurance information, etc).

We accept cash, checks, MasterCard, or Visa. (Make Checks Payable to: Galichia Medical Group) Your bill might include office visits, procedures, nuclear testing, electrocardiograms, treadmills, ultrasound studies, laboratory, or other charges. You may also receive bills from outside radiology and laboratory clinics that we utilize, as well as other physicians and / or surgery centers if your procedure is not performed in our clinic. As a courtesy to you, we file your claims to your insurance company. Amounts not covered by your insurance are your responsibility. ALL CO-PAYMENTS MUST BE PAID AT TIME OF SERVICE OR YOUR APPOINTMENT WILL BE RESCHEDULED. WE CANNOT WAIVE CO-PAYS AND DEDUCTIBLES FOR SERVICE(S) PROVIDED. IF YOU DO NOT HAVE INSURANCE AND ARE A NEW PATIENT AT OUR FACILITY YOU WILL BE REQUIRED TO ESTABLISH A PAYMENT PLAN WITH OUR FINANCIAL REPRESENTATIVE AND MAKE A PARTIAL PAYMENT OF $125.00 AT THE TIME OF YOUR VISIT. IF YOU ARE AN ESTABLISHED PATIENT WITH NO INSURANCE COVERAGE YOU WILL BE REQUIRED TO MAINTAIN A PAYMENT PLAN AND MAKE A PARTIAL PAYMENT OF $50.00 AT THE TIME OF YOUR VISIT.

INSURANCE:
It is the patient's responsibility to provide the clinic with current insurance information. Our relationship is with YOU, not your insurance company. Kansas law states that clean insurance claims should be paid within 30 days from receipt (K.S.A. 40-2442). Please call your insurance company if your bill is not paid promptly.

REFERRALS:
If your insurance plan requires you to have a referral to be seen in our office, it is your responsibility to obtain a referral from your primary care physician and ensure our office has a current copy. If our office does not have a current referral on file, you will need to sign a self-referral form at the time of your appointment stating that you will be responsible for payment in full for that day's service. If you do not wish to sign a self-referral, you may be asked to reschedule your appointment until you can get a referral from your primary care physician.

MINORS:
The parent / guardian that signs this Patient Financial Policy will receive the billing statements for the minor and will be responsible for payment on the minor's account.

MISCELLANEOUS FEES:
Missed appointments: If you fail to cancel your procedure (including colonoscopy, endoscopy, heart catheterization, pacemaker, etc) appointment prior to 24 hours of the time the surgery is scheduled, you may be subject to a $100.00 fee. If you fail to cancel your clinical appointments prior to 24 hours of the time your appointment is scheduled, you may be subject to a $50.00 fee.
Form Completion: There is a minimum fee of $25.00 to complete supplemental forms such as FMLA and disability claim. As a courtesy and at your request, we will provide a free copy of medical records to another physician for continuity of care. Patients requesting a copy of their medical record will be charged a fee of $25.00 for the first copy. Additional copies will be billed at the standard retrieval rate. These fees must be paid in full before the service will be performed. Please allow 30 days for completion of any forms and for copies of records.
Multiple Billing: A fee of $5.00 will be billed for each additional statement over two statements sent.
Returned Checks: There is $30.00 fee for any check returned for insufficient funds.
Collection Fees: GMED shall have the authority to charge and assess collection costs and expenses, including reasonable attorneys; fees , and penalties and interest for the late payment or non-payment thereof.

Thank you for understanding our Financial Policy. We appreciate the opportunity to provide our services to your medical needs. Your assistance and cooperation will be most appreciated. Should you have any questions or concerns, please contact us.

I have read and understand the Financial Policy and realize this policy is subject to change without notice:

_____ _____

PRINT - Patient Name SIGNATURE - Patient/Responsible Party

_____ _____

Staff Signature Date