



Bibb Family Practice Associates, PC
Sam G. Amporful, M.D.
721 RIVERSIDE DRIVE LANE
MACON, GA 31201
(478) 259-3439

Patient Name: _____

DOB: _____

Office and Financial Policies

Welcome to Bibb Family Practice. Our goal is to provide you with quality care by qualified Medical Physician. Below are a few policies to review and sign.

Co-pays / Coinsurance

The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted.

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Insurance Claims

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

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Self-pay Accounts

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. Liability cases will also be considered self-pay accounts. We do not accept attorney letters or contingency payments. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Self-pay patients will be required to bring \$100 at the initial appointment. Extended payment arrangements are available if needed. Please ask to speak with a billing coordinator to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

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Additional Document Fees Not Covered By Insurance

FMLA Paper	\$35.00
INS Form	\$35.00
Medical Records	\$25.00
Disability Parking Permit	\$10.00
Immunization Form	\$10.00

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Missed Appointments

Bibb Family Practice requires 24-hour notice of appointment cancellation. Appointments missed and are not previously cancelled may be charged a fee of **\$35.00**. Repeat cancellations and more than two consecutive no shows may result in limited medication refills and/or possible discharge from our practice.

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Returned Checks

The charge for a returned check is \$35 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

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Outstanding Balance Policy

It is our office policy that all past due accounts be sent two statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collection costs including attorney fees and court costs.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

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This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

Patient Name: _____ **Date:** _____