MIDWEST REGIONAL HEALTH SERVICES, LLC

FINANCIAL POLICY

Welcome to your home for better health! Thank you for choosing our practice. We are committed to your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

All patients must complete our Patient Information Form. We will require seeing your insurance card at every visit and will request a copy of your insurance card every six months. Obtaining necessary information upfront will enable our billing staff to bill your insurance both timely and appropriately. Patients are responsible to notify our office in the event of insurance or other demographic changes.

Payment Methods: We accept payment by cash, check, VISA and Mastercard. In the event we receive a return check, an addition fee of $35.00 will be added to your account.

Co-Payments: Co-payments are due at the time medical service is rendered. In the event you arrive without the co-payment, the front desk staff will be happy to re-schedule your appointment.

Missed/Cancelled Appointments: We would appreciate the courtesy of a call if you are unable to keep an appointment. Please notify our office at least twenty-four (24) hours prior to the appointment time. We reserve the right to charge you a fee of $25.00 when not given 24 hours notice. Also three (3) non-cancelled missed appointments are grounds for patient discharge.

After Hour Appointments: Appointments scheduled with a physician outside the normal office hours are considered "after hours" appointments. An additional charge of $15.00 will apply to all appointments scheduled during these times.

Virtual Office visits: These visits are for acute symptoms only as listed on our portal and will result in a $35.00 fee due at the time of service.

Payment Terms: Payment is expected within 30 days following statement receipt unless other arrangements have been made with the billing office. Unpaid accounts beyond 90 days are considered delinquent and may be forwarded to our collection agency.

I agree to be fully responsible for all lawful debts incurred by myself for services received from Midwest Regional Health Services, LLC whether covered by my insurance or not.

I have read, understand, and agree to the Financial Policy. I understand that charges not covered by insurance, as well as any applicable co-payments and/or deductibles, are my responsibility.

I authorize my insurance benefits to be paid directly to Midwest Regional Health Services.

I authorize Midwest Regional Health Services to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

_____	_____
Signature of Patient or Legal Guardian	Relationship to patient
_____	_____
Patient's Name	Date