

# West Omaha Family Physicians, P.C.

17030 Lakeside Hills Plaza, Suite 130, Omaha, NE 68130 • Phone: (402) 758-5150 • Fax: (402) 758-5158

## FINANCIAL POLICY

Thank you for choosing West Omaha Family Physicians, P.C. The following is a statement of our FINANCIAL POLICY. All patients must accept our FINANCIAL POLICY before receiving treatment.

## METHOD OF PAYMENT

We accept CASH, CHECK, VISA, and MASTERCARD. Payment plans may be arranged on an individual basis with our Billing Manager.

## REGARDING YOUR INSURANCE

As a courtesy to you, we will submit medical claims to your insurance company. Any balance after processing of our claim by your carrier is your responsibility. Your insurance policy is a contract between you and your insurance company. You are responsible for verifying if providers are in-network with your insurance company. We cannot bill your insurance company unless you give us your complete insurance information. It is your responsibility to know your insurance benefits as it may not cover all of the services provided to you.

## DEFINITIONS

**CO-PAYMENT:** A fixed dollar amount set by your insurance contract that is required to be paid at the time of an office visit. This amount is usually between \$15.00 and \$50.00 and is usually noted on your insurance card. All co-pays are due at registration for your appointment.

**DEDUCTIBLE:** An annual dollar amount established by your insurance plan that is deducted from insurance benefits. This amount is your obligation.

**CO-INSURANCE:** A percent set by your insurance plan that is deducted from your insurance benefits. If you do not have a co-pay amount, then a co-insurance amount of 20% will be charged to you at the time of your visit. (Medicare/Medicaid patients will not be charged this at the time of service). Medicare patients will be billed after Medicare pays.

**SELF-PAY:** A patient that does not have any valid health insurance. You will be asked to pay for services at the time of your appointment.

## MVA POLICY

We will NOT file your insurance claim to your motor vehicle insurance. We will collect your personal insurance information at the time of service to file to if payment from your MVA is not received within 60 days of service. If insurance has not paid this claim within 90 days, the amount due will become the patient's responsibility.

## PERSONAL INJURY (LIABILITY)

We require a financial arrangement be established for payment in full at the time of service for personal injury cases. We will file a claim with your personal insurance if you wish, but you will still be required to do the above financial arrangements.

## WORK RELATED INJURIES

We will file Workers Compensation claims with your employer's Workers Compensation insurance carrier. Written or telephone authorization is required from your employer and/or insurance company prior to treatment. If prior authorization is not obtained, you are responsible for full payment at the time of service. If your company's workers compensation carrier has not paid your account in full within 90 days of your date of service, the balance will be transferred to your account and it is your responsibility to pay in full by the statement due date.

## RETURNED CHECKS

A \$20.00 service fee will be added to all checks returned for insufficient funds. If your check is returned, you will be required to pre-pay in full by cash or credit card for additional services.

## COLLECTION ACCOUNTS

All services after an account has been given to a collection agency will be on a CASH ONLY basis. All co-pays and deductibles will be collected at the time of service. If you are unable to comply your appointment will be rescheduled.

I acknowledge that I was offered a copy of the Financial Policy named at the top of this page.

PATIENT INFORMATION

LAST NAME		FIRST NAME		MIDDLE INITIAL	SOCIAL SECURITY NUMBER	CELL PHONE
ADDRESS			CITY	STATE	ZIP	HOME PHONE
DATE OF BIRTH	GENDER	MARITAL STATUS	EMPLOYER	OCCUPATION	WORK PHONE	

SPOUSE INFORMATION

LAST NAME		FIRST NAME		MIDDLE INITIAL	SOCIAL SECURITY NUMBER	CELL PHONE
ADDRESS			CITY	STATE	ZIP	HOME PHONE
DATE OF BIRTH	GENDER	RELATIONSHIP <b>Spouse</b>	EMPLOYER	OCCUPATION	WORK PHONE	

PARENTS INFORMATION

LAST NAME		FIRST NAME		MIDDLE INITIAL	SOCIAL SECURITY NUMBER	CELL PHONE
ADDRESS			CITY	STATE	ZIP	HOME PHONE
DATE OF BIRTH	GENDER	RELATIONSHIP <b>Mother</b>	EMPLOYER	OCCUPATION	WORK PHONE	

LAST NAME		FIRST NAME		MIDDLE INITIAL	SOCIAL SECURITY NUMBER	CELL PHONE
ADDRESS			CITY	STATE	ZIP	HOME PHONE
DATE OF BIRTH	GENDER	RELATIONSHIP <b>Father</b>	EMPLOYER	OCCUPATION	WORK PHONE	

SIGNATURE INFORMATION

\_\_\_\_\_  
PATIENT/REPRESENTATIVE SIGNATURE

\_\_\_\_\_  
DATE