WEST WICHITA FAMILY PHYSICIANS, P.A.
FINANCIAL POLICY

The following is a statement of our Financial Policy which we would like for you to read and sign.

West Wichita Family Physicians, P.A. is committed to providing quality care for our patients and our charges are what are usual and customary for our area.

We will file your primary and secondary insurance claims as a courtesy to the insurance company that we have on file. If your insurance company has not paid your account in full within ninety (90) days, the balance will automatically become your responsibility. If a problem occurs with your claim you will be asked to contact your insurance company to help resolve the problem. You will also be expected to make monthly payments on your account until the problem is resolved.

You are responsible for the timely payment of your account. Each month you will receive a statement for services which is due and payable upon receipt. Our minimum monthly payment is $50.00. We accept cash, check, Visa, MasterCard, or Discover. If a check is returned from the bank a $20.00 charge will be applied to your account. If you are experiencing a set of circumstances out of your control, please call **316-722-6260** and we will be happy to discuss other options.

ONE TIME AUTHORIZATION

In order to submit a claim for payment directly to your provider for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the physician indicated on the claim.

I have read the Financial Policy. I understand and agree to this policy.

_____ _____

Please print name of patient Date of birth

X_____ Date_____

Signature of Patient or Responsible Party