West Wichita Family Physicians, P.A. Patient Financial Policy
Effective: January 2020

Thank you for choosing West Wichita Family Physicians, P.A. (WWFP) as your healthcare provider. The medical services you seek may require a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. To assist in understanding your financial responsibility, we ask that you read and sign this policy.

1. **Copayments**: Your insurance plan requires copayments be paid at time of service. If you are unable to pay your copayment, you will need to reschedule your appointment.
2. **Insurance:** WWFP will submit your primary and secondary insurance claims to the insurance company we have on file. You are responsible for the patient portion of the balance after insurance has paid.
3. **Forms of Payment**: WWFP accepts cash, check, Visa, MasterCard, Discover, and American Express. A fee of $20 will be charged on returned checks.
4. **Patient Statements**: Patient statements will be generated after WWFP has received payment from your insurance company.
5. **Statement Processing Fee**: After two patient statements of non-payment, a $10 statement processing fee will apply on each future monthly patient statement until account is paid in full. This fee will not be covered by your insurance.
6. **Patient Payment Plan Agreement**: Patient may set up a payment plan agreement with WWFP. Automatic recurring deduction of a credit or debit card on file is required for ongoing payments.
7. **Credit Card on File**: All patients are required to have a credit or debit card on file with our office. The card number will be securely encrypted offsite with a third party data center. Delinquent accounts greater than 90 days without a Patient Payment Plan Agreement will be charged the patient balance in full.
8. **Patient Account Balance**: Non-payment on your account balance over 90 days and failure to maintain a current credit or debit card on file with our office may result in collection of payment via an external Collection Agency unless you have set up a Patient Payment Plan Agreement.
9. **Self-Pay**: If you do not have current health insurance coverage, you will be responsible for $50 payment at time of service and any remaining balance must be paid in full before next appointment.
10. **No-Show Appointments**: 24 hour cancellation notice is required to cancel an appointment. If patient fails to cancel an appointment a $50 cancellation fee will apply to wellness exams and in-house surgeries. A $100 cancellation fee will apply to radiology services. This fee will not be covered by your insurance.
11. **FMLA/Disability Forms**: A fee of $20 will be charged to the patient for completing FMLA or disability forms. Payment is required when forms are received. This fee will not be covered by your insurance.

WWFP believes a good physician/patient relationship is based on understanding and communication. By signing the WWFP Patient Financial Policy, you understand and agree to this policy.

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Patient Name (Print) Date of Birth

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Patient/Responsible Party (Signature) Date