

**ANDREWS INTERNAL MEDICINE, PA**  
**FINANCIAL POLICY**

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In order to reduce confusion and misunderstanding between our patients and the practice we have adopted the following financial policy. If you have any questions about the policy please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding or your financial responsibilities as an essential element of your care and treatment. Unless other arrangements have been made in advance by either yourself or your health coverage carrier, **FULL payment is due at the time of service.** For your convenience we will accept VISA or MasterCard.

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**YOUR INSURANCE**

We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans for whom we have an agreement and will only require you to pay the authorized co-payment plus deductible at the time of service. It is the policy of our office to collect the co-payment when you arrive for your appointment.

If you have insurance coverage with a plan that we do **not** have a prior agreement we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. The charges for your care and treatment are due at the time of the service.

In the event your health plan determines a service to be “not covered”; you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

**MINOR PATIENTS**

For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

**I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.**

\_\_\_\_\_  
*Signature of Patient or Responsible Party if a Minor*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of Co-responsible Party*

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*Please PRINT the Name of the Patient*