Financial Policy

As a courtesy to our patients, we will file your insurance for you if you have a copy of the card in your possession. We must have all pertinent information in order to extend this courtesy. In the event that you are a self-pay patient, please arrange to pay in full at the time of service.

We are participating providers for Aetna, Anthem, Cigna, PCHP, Southern Health, Tricare, United Health Care and Medicare. You are required to pay any applicable co-pay or yearly deductible at the time of service. Our policy is to collect co-pays during the check in process.

If your insurance plan requires a primary physician (PCP), one of our physician's names must be printed on your card in order for us to see you.

If you have an outstanding balance at the time of your next office visit, you will be expected to clear that balance up prior to being seen. You will receive statements from our billing office, Benchmark Systems, while your balance is current to 59 days old. If your account becomes 60 days past due, you will receive a letter from us asking for remittance. Should the account go 90 days past due, you will receive a second notice with a warning that your account is in jeopardy of going to an outside collection agency. Once your account is turned over to collections, you will be discharged from the practice. The entire amount of the bill, interest, court costs; collection fees and/or attorney fees will be due, whether or not suit is commenced.

You may receive a separate bill from our outside lab, Centra Lab; our office will notify you of your results if they are abnormal, which may require a follow up visit.

If you are unable to keep an appointment, please telephone us in advance.

We accept Mastercard, Visa, check or cash. Please be advised there is a $35.00 fee for returned checks.

Financial Agreement

I have read and understand the above and agree to my responsibilities as a patient. I also understand and agree that I will be responsible for any and all fees incurred and am responsible for any and all collection fees and/or attorney's fees if this account is turned over to a collection agency, whether or not suit is commenced.

Patient's Signature_____ Date _____

Parent's Signature if patient is a minor_____

General Consent for Treatment

I hereby authorize the Physicians at Wiggington Road Family Practice and their staff to perform and do hereby consent to such medical care as deemed necessary, including diagnostic procedures, medical examinations and treatment as may, in the physician's opinion, be medically necessary.

I am aware that the practice of medicine in not an exact science and I acknowledge that no guarantees have been made to me as to the result of any procedure, treatment or examination.

Patient Name _____
(please print)

Patient Signature _____ Date_____
(parent if patient is a minor)

Medical History Information

Patient Name_____

Current medical problems_____

Past medical problems_____

Surgeries_____

Please list your medications (include over-the-counter and herbals) and their dosages

_____

_____

_____

Pharmacy preference_____

Please list known allergies_____

_____

Please list any medical problems of your relatives_____

_____

Number of children_____

Tobacco usage and amount_____

Alcohol or drug usage and amount_____

Do you have an Advanced Directive or DNR (Do Not Resuscitate)?_____

Are your immunizations up to date?_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in completion of this form.

_____ _____

Signature of patient or parent if minor **Date**