OVERLAKE FAMILY MEDICINE

Financial Policy and Consent Form

1. Payment is requested at the time of service; this includes but is not limited to co-payments, deductibles, and non-covered services. We accept cash, checks, MasterCard and Visa.
2. As a courtesy, we will bill your PRIMARY insurance for you and send any necessary reports to assist with reimbursement. We will bill your SECONDARY insurance for you as a courtesy.
3. All Balances are due within 60 days of initial billing. SPECIAL NEEDS: Special needs are understood by this office. It may be necessary to set up a payment plan for a patient requiring extensive treatment. If this situation is necessary for you, please bring this to our attention as soon as possible.
4. Legal agreements between parents accepting or denying financial responsibility for medical bills are not recognized by this office. The parent who brings the child for medical care is responsible for the payment of services.
5. TO OUR MEDICARE PATIENTS: We are Medicare providers. Because of all the new laws and changes in allowed and non-covered services, we will bill Medicare for services rendered, however it is office policy to have all Medicare patients sign a waiver at each office visit that holds the patient responsible for any services that are non-covered.
6. A finance charge of 1% per month, up to 12% per year is applied on all accounts 60 days past due.
7. We will make every effort to expedite accurate claims to your insurance company for prompt reimbursement, but the agreement of the insurance company to pay for your medical care is a contract between you and the insurance company. The bill remains your responsibility.
8. USE/DISCLOSURE OF PERSONAL HEALTH INFORMATION AND ASSIGNMENT: By signing on the line below this paragraph, you give consent for the doctor and the insurance company to use and/or disclose any personal health information required to process your medical claims, perform any required medical treatment or perform required administrative operations. You may refuse to give consent to use and/or disclose your personal health information for treatment, payment and operations, but in so doing, OVERLAKE FAMILY MEDICINE may refuse to provide you with treatment services. You have the right to revoke your consent in writing to the extent that the doctor, the billing service company, and the insurance company have taken action in reliance on your original consent. Furthermore, by signing on the line below you authorize your insurance benefits to be paid directly to OVERLAKE FAMILY MEDICINE.

Please sign in the space provided to indicate that you understand the financial policy, use and disclosure of information, and assignment:

Signed:____ Dated: ____________________

3080 148th Ave SE Ste 115, Bellevue, WA 98007 PH: 425.378.8190 FAX: 425.649.1523