West Marin Medical Center
MARIN HEALTHCARE DISTRICT

Financial Policy

Thank you for choosing us as your healthcare provider. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we ask that you read and sign prior to treatment.

All charges incurred for services in the office will be due and payable at the time service is rendered.

Exceptions: Medicare, Medi-Cal, Health Maintenance Organizations (HMO), and Preferred Provider Organizations (PPO). However, all co-pays, deductibles and other appropriate payment responsibility per contract will be collected at the time of service.

Co-Pays: All co-pays are due and payable at the time of service in accordance with the legal requirements prohibiting writing off patient responsibility amounts. You have agreed to be responsible for your co-pay and wall will be paid at the time of service or your appointment may be rescheduled.

Charity Care: We provide charity care on a sliding scale for patients demonstrating a financial need.

Proof of Insurance: You are responsible for providing the physician office with correct and accurate insurance information so that we may bill your insurance company and receive payment in a timely fashion. You must bring your insurance card with you at each visit. At each visit you will be asked to review that the information is correct. We will bill your insurance company for you, however you are responsible for the payment and the amount is due at the time of service with the exceptions noted above.

Second Insurance: We will bill your second insurance once. However, you are responsible for the balance, and the balance owed after payment received from primary carrier will be transferred to you. We will not bill your second insurance for co-pays.

Payment Methods: We have a variety of payment methods available including cash, check, and credit card.

Usual and Customary Rates: We charge what is usual and customary for our area. You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary rates.

Medicare Non-covered Procedures: You are responsible for any non-covered services and will be asked to sign a waiver indicating responsibility for payment.

Non-sufficient Funds Checks: All checks received for payment of services and returned by the bank marked "non-sufficient funds" will be charged to you and a non-sufficient check processing charge of $15 will be charged.

No Show Appointments: We understand that occasionally you will be unable to make scheduled appointments due to emergencies. However, it is expected that you will notify the physician's office within 24 hours of appointment and reschedule the appointment. If you fail to notify the office of a cancellation within 24 hours of your scheduled appointment, a charge of $35 may be added to your account.

Receipts: We wish to ensure that all patient payments are credited appropriately. Our staff will provide you a receipt for your payment. If the staff should fail to provide you a receipt, please ask for one.

Insurance Coverage: Please be aware that insurance coverage varies with each plan. It is your responsibility to be familiar with your plan. It is your responsibility to know if annual exams are a covered benefit.

I have read, understand and agree to the financial policy.

Patient Name _____

Signature _____

Date _____