



FINANCIAL POLICY STATEMENT

We would like to thank you for choosing The Jackson Clinics, LLC and allowing us to provide your healthcare needs. The policies listed herein have been approved by the management with the goal of providing the finest care and service to our patients at the least cost.

Care delivered by this facility will be administered regardless of race, color, creed, social status, national origin, handicap or gender.

We are committed to providing you with the best possible care. In order to accomplish this, we need your assistance in reading and understanding financial responsibility and our payment policy.

RESPONSIBILITY FOR THE BILL

It is the expectation that all patients/guarantors receiving services are financially responsible for the timely payment of the charges incurred. While the clinic will file verified insurance for payment of the bill(s) as a courtesy to the patient, the patient/guarantor is ultimately responsible for payment and agrees to pay the account(s) in accordance with the regular rates and terms of the clinic in effect at the present time.

POINT OF SERVICE COLLECTIONS

Payment for service is due at the time to service(s) is rendered and non-emergency services may be declined until the necessary payment arrangements have been accomplished.

Payment will be accepted in cash, checks, and most major credit/debit cards. We will be happy to file verified insurance on your behalf. For your convenience if your check is dishonored or returned for any reason, we will electronically debit your account for the amount of the check plus a processing fee of \$50.00.

Patients unable to comply with the Point-of-Service payment policy will be referred to the administrative office for necessary arrangements.

PAYMENT ARRANGEMENTS

The clinic will make a reasonable effort to assist patients in meeting their financial obligations. Financial arrangement for payments will be made at the clinic's discretion, based on the amount of the patient's liability and the patient's ability to pay based on a completed credit application.

PATIENT SCHEDULING

Every effort will be made to schedule the patient at the patient's convenience. Patients will be advised of the clinic payment policy at the time appointments are made along with the best estimate of the cost of the office visit.

ACCEPTANCE OF INSURANCE

The clinic will accept "Assignment of Benefits" on verified insurance policies and submit a bill to the carrier on the patient's behalf. It is understood that insurance is filed as a courtesy to the patient and does not relieve the patient of financial responsibility. Claims filed will be held 45 days pending payment. The patient/guarantor will be responsible for payment in full on all the claims not paid within the allowed period of time.

VERIFICATION OF INSURANCE

Because of the wide range of insurance plans in effect, the clinic will verify insurance coverage, deductibles and other limits, prior to acceptance for payment of services.

PRE-CERTIFICATION

The clinic will make every effort to pre-certify all services, provided the clinic is supplied with the necessary information.

REJECTED CLAIMS

Our staff is trained to assist you with insurance questions. COVERAGE ISSUES can only be addressed by your employer or group health administrator. Although our assistance is available, we cannot act as a mediator on your behalf.

RELEASE OF INFORMATION

By signing our release of information form, you provide us with the authority to release such information as is necessary to collect from insurance companies and other third party payers.

PATIENT RESPONSIBILITY

Balances after insurance are due within 30 days of the insurance payment, unless other satisfactory arrangements have been made with the clinic.

Not all services are covered by all insurance companies. It should be understood that by accepting the service(s), the patient is responsible for payment regardless of the fact that insurance covers the service or not.

The clinic cannot become involved with any third party liability matters and must always look to the patient/guarantor for payment of the bill.

OUTSTANDING BILLS

The clinic reserves the right to request deposits and payments for outstanding balances. Deposits will be based on the outstanding balance plus the patient’s share of the bill for the new services to be performed.

HEALTHCARE LIENS

The clinic reserves the right to file healthcare liens against the patient and other responsible parties as is deemed appropriate to protect the clinic interest.

BAD DEBTS/LEGAL ACTION

If the account is not paid in full or satisfactory arrangements made within the allowable time frame, the clinic reserves the right to refer the account to an attorney and/or a collection agency for collection of the balance.

I agree to assume responsibility for all charges incurred should collections of this balance become necessary including court costs and attorney’s fee.

The administrative and management welcomes the opportunity to discuss any aspect of the financial policy. We appreciate your confidence and strive to provide quality healthcare.

In the event that The Jackson Clinics must file a law suit to collect a debt, I agree the jurisdiction shall be in the courts of Loudoun County, VA.

I have read the *Financial Policy/Policy Statement* and understand regarding above.

Patient/Guarantor Signature Print Name Date

Witness-Staff Employee Signature Print Name Date