Agave Family
Physicians, PLLC

Financial Policy

Agave Family Physicians must emphasize that, as your medical care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company(s). We will cooperate fully with the regulations and requests of your insurance company that may assist in processing your claim. However, our office will not enter into a dispute with your insurance company over processing your claim.

- _____ I understand that coordinating benefits with my insurance company(s) is entirely my responsibility. In the event that a claim is denied because of improper coordination of benefits, I understand that I am responsible for the entire balance due.

- _____ I understand that it is my responsibility to provide Agave Family Physicians with current insurance information at the time of the office visit. I agree to inform AFP of any changes to my insurance coverage. In the event that a claim is denied because of incorrect insurance information, I understand that I am responsible for the entire balance due.

- _____ I understand that my insurance company(s) may require additional information from me to process a claim. In the event that a claim is denied because I have not submitted the requested information in a timely manner, I understand that I am responsible for the entire balance due.

- _____ I understand that Agave Family Physicians is NOT a Workers Compensation provider and that I am responsible for the entire balance due resulting from services rendered.

- _____ I understand that copayments are due at the time of service. I understand that any charges not covered by my insurance company(s) are my responsibility. Agave Family Physicians accepts cash, personal checks, money orders, Visa, MasterCard and Discover. We cannot accept postdated checks.

- _____ I understand that, in the event that I fail to make payment on my balance, a $25 fee will be added to my balance for each 30 days my balance is outstanding.

- _____ I understand that, in the event I default on payment of my balance, I will be sent to collections and discharged from the practice. I understand that I will pay collection costs and reasonable attorney's fees incurred by Agave Family Physicians while attempting to collect the balance due. I understand that an additional charge of 30% of the balance due will be added to the balance.

- _____ I understand that, in the event that payment made by check is returned by the bank for insufficient funds, a $25.00 dishonored check fee will be added to the balance due. I understand that all future payments will need to be made in cash, certified funds or credit card and that AFP will no longer accept payment from me for services rendered.

I acknowledge understanding of the above financial policy and agree to abide by it.

Printed Name : _____ Date : _____

Signature : _____ Relationship To Patient : _____