PIONEER
Family Practice, PLLC 5130 Corporate Center CT SE, Lacey, WA 98503 Phone: 360-413-8600/Fax: 360-413-8822

FINANCIAL POLICY AND AGREEMENT

The following is a statement of our **Financial Policy** which we require that you read and sign prior to any treatment. You, not any other third party, are ultimately responsible for payment of services you receive at Pioneer Family Practice. Please read and sign this agreement. If you have questions or need clarification, please ask the receptionist.

REGARDING INSURANCE: As a courtesy, this office will submit claims to your insurance carrier(s). In order to facilitate claims processing, you must provide all current insurance policy information. If you have secondary insurance, we will bill them after your primary insurance processes the claim. Your insurance is a contract between you and your insurance carrier, your involvement is expected on any claims older than 60 days. You are responsible for knowing what your insurance covers and the providers and network(s) covered by your insurance company. If your insurance carrier has not paid your full account balance within 90 days, you must pay the outstanding balance without delay. We accept assignment of benefits if you are insured by one of the following.

FOR NEW PATIENTS:

Aetna
Cigna
Federal Premera/Regence
Regence Blue Shield (**NOT** PSHVN)
First Choice Administrators
First Choice Health Network
Premera (**NOT** Medicare Adv plan)
Group Health-*OPTIONS*
Uniform by Regence
Health Care Management-HMA-preferred
UW Medicine ACN (NOT High-Value Network)

FOR ESTABLISHED PATIENTS ONLY:

DSHS
CHPW-basic health & healthy options
Medicare & Medicare Advantage plans
United Healthcare Healthy Options
Amerigroup
Tricare Prime & Standard
United Healthcare
Labor & Industries (including self-insured)
Sound Path Health/Humana/Health Alliance

CO-PAYS: Insurance companies require their contracted patients to pay their co-pay at the time of service. *Per insurance company contractual requirements, we will collect your co-pay at each appointment.* Failure to pay at the time of service may result in a $10.00 statement fee.

NO INSURANCE-CASH PAY PATIENTS: Patients who have no insurance are required to pay $50.00 at the time of service for each visit and make payment arrangements for the balance. We accept cash, check, debit card, and VISA/MasterCard/Discover. Payment in full allows for a 20% discount for the entire visit's billing.

NO SHOW POLICY: Please call to cancel your appointment at least 24 hours prior to the scheduled time, to allow us to schedule another patient for that time. Last minute cancellations and missed appointments, will be considered a no show. If you no show for your first visit to the clinic, we may not accept you as a patient in the future. If you are an established patient, we reserve the right to charge $30 for no shows. ***The $30 no-show fee is due prior to your next appt.*** We also reserve the right to dismiss patients from the practice who no show repeatedly.

Forms: The turnaround time for completing paperwork is generally 3-5 business days. We now charge a fee for completion of certain types of paperwork. The provider completing the paperwork will determine if a charge is warranted and the amount to charge, which will generally range from $15.00 to $45.00. For paperwork with an associated charge, payment in full will be collected when you pick up the completed paperwork.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT: We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may get a copy of our **Notice of Privacy Practices** which describes in more detail how your health information may be used and disclosed and how you can access your information.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health information to the persons indicated below: ***CIRCLE ONE***

ANY MEMBER OF MY IMMEDIATE FAMILY	YES	NO	Can we leave a message on your cell phone?	YES	NO
SPOUSE	YES	NO	Can we leave a message on your home phone?	YES	NO
OTHER: (*please specify*)	YES	NO			

By my signature below I acknowledge receipt of the Financial Policy and Notice of Privacy Practices & have read & understand them.

_______________________________ Date: ______________ Time: ______________
Patient or legally authorized individual signature

_______________________________ Relationship to patient: ______________
Printed name if signed on behalf of the patient

This form will be retained in your electronic medical record. Staff Initials_______ Updated 8/11/16