Internal Medicine of West Michigan
3200 Eagle Park Drive, NE. Suite 102 Grand Rapids, MI 49525

Financial / Office Policy

At Internal Medicine of West Michigan we desire to provide quality care for you. We consider it a privilege that you have chosen us as health care providers for your medical care.

Insurance

- Your health insurance is a contract between you and your insurance company. You are required to know what is and what is not covered by your insurance. If you have any questions regarding your insurance coverage call your insurance company.
- We participate in many insurance plans. This means that our office will accept assignment of benefits. You are responsible for deductibles, co-payments and "non-covered" services.
- If you have insurance plan that we do not participate with, our office will file a courtesy claim for you. You are responsible to pay the entire charge within 45 days of service.

Payment for services:

- We currently accept Cash, Check, Visa, MasterCard and Discover. Please note that a service fee of $20.00 will be assessed for returned checks.
- Co-payments are expected at the time of service. Starting with your next visit, if the co-pay is not paid at the time of service a $10.00 billing fee will be added to your account.

Financial Hardship:
If you are facing financial difficulties, call the billing office so we may make arrangements for payment.

Overdue Payments:
Accounts over 90 days past due will be referred to a Collections Agency. Failure to pay for services already provided may result in discharge from our practice.

Missed Appointments:
Our "no show" policy (this does not include cancellations made 24 hours prior to the visit time) states that after 3 no shows you may be discharged from the practice at the physicians discretion.

Forms:
Our office will charge a $10.00 fee for any forms that your physician needs to fill out. This charge is not billable to your insurance company.

I understand according to the State of Michigan Department of Health, Act 488 of 1988 that if a health care professional in this practice sustains a cutaneous, mucous membrane or open wound exposure to blood or other body fluids from myself that a HIV and Hepatitis-B (BBV) blood test will be preformed.

I have read and understand Internal Medicine of West Michigan financial / office policy.

I certify that the insurance information that I have given is correct. I will notify Internal Medicine of West Michigan of any future changes in my health insurance. I authorize the release of any medical information necessary in order to process a claim with my insurance company. I authorize payment made directly to Internal Medicine of West Michigan. I permit a copy of this authorization to be used in place of the original.

Print Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Parent / Guardian: _____ Date: _____