Hayward Family Care

27206 Calaroga Ave. Suite 207 Hayward, CA 94545
Phone: (510)887.4711 Fax: (510)887.2470

Robert Rowley M.D. Family Practice * **Linda Deivert PA-C** Family Practice
Sonal Aggarwal M.D. Family Practice * **Veena Gowra M.D.** Family Practice

Patient Financial Policy

This is an agreement between Hayward Family Care and the Patient/Guarantor named on this form. By executing this agreement, patient/guarantor agrees to pay for all services rendered.

Co-payment: Payments for co-pays are due at each and every visit.

**Patient must provide the insurance card/ proof of insurance and photo identification at each visit.*
**Patients are fully responsible for obtaining any necessary changes with the insurance carrier regarding PCP assignment. Each physician, physician assistant/ and or facility may not be contracted with the insurance plan. It is the responsibility of the patient to verify insurance coverage and eligibility prior to seeing the healthcare provider*

Monthly Statement: If patient has a balance on their account, our office will send a monthly statement. It will show the previous balance and any new charges to the account.

Information for Self-Pay Patients: In order to make our services accessible to patient lacking health insurance coverage, our practice offers a significant 20% discount for self-pay patients when paid on day of services rendered.

**New patients:* Payment is expected the day of the doctor visit. Patient may pay by cash, check, or credit card.
**Established patients:* Patient may be billed for services but will not receive the 20% discount

Information for Insured Patients: We participate with most health insurance plans. Patients with active health insurance must have benefits verified before each visit.

Medicare/Medi-Cal: We participate with both Medicare and Medi-Cal. We agree to bill and accept contractual adjustments and will not apply interest or finance charges to these accounts. There may be services and supplies rendered that are not covered by Medicare and therefore require and Advance beneficiary Notice (ABN) be signed by the patient /guarantor. By signing the ABN, patient/guarantor understands that it is their responsibility to pay non covered services.

Insurance is a contract between the patient and the insurance company. In most cases we are NOT a party in this contract. We will bill the primary insurance carrier as a courtesy. In order to properly bill them we require that the patient disclose all information including primary and secondary insurance as well as any change in insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what the insurance company may pay, it is the insurance company that makes the final decision. If the patient's health insurance is not contracted with us, guarantor agrees to pay any portion of the charges not covered by the insurance, including but not limited to those charges above the usual and customary allowance. If we are out-of-network with the patient's health plan and the insurance pays the patient directly, the guarantor agrees to forward the payment to our office immediately.

Please initial to indicate that the patient/guarantor have read this page ______________

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Missed Appointments/Same Day Cancellation: Our office will send an Email notification to patients that provide us with their email address in efforts to remind the patient of his/her appointment. If the patient fails to inform us within *24 hours* of his/her inability to make it to his/her scheduled appointment, the patient is subject to a failed appointment charge of *$25* for regular visits and *$50* for physical or pap appointments. The missed appointment charge with not be billed to the insurance. This amount is considered *patient responsibility.*

Returned Checks: There is a fee of *$25* on any checks returned by the bank. We may choose to proceed with legal action which may result in additional fees.

Past Due Accounts: If patients account becomes past due, we will take the necessary steps to collect this debt. If we have to refer the patients account to a collection agency, guarantor agrees to pay all legal fees that we incur plus all the court costs.

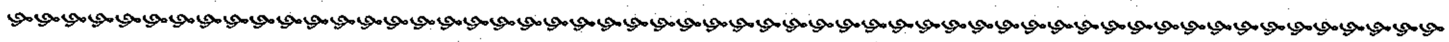
Waiver of Confidentiality: We have the option to report patients account status to an attorney, collection agency, credit reporting agency such as American Credit Bureau Inc., or for court litigation; and the fact that the patient received treatment at our office may become a matter of public record.

Transferring of Records: In order to forward patient records to another doctor or organization, we require the patient to complete a release of records form. If the patient request to have a copy of his/her records, there is a copy records fee of *$35.*

Form Processing:
Disability paperwork: $10 each form.
Letters (jury duty exemption, etc.): $10
DMV Handicap Placard Request: $5
Life Insurance Form: $5

You are responsible for these fees, and your insurance cannot be billed for them.
The paperwork fees are in addition to any charges for the usual office visit, and are subject to change depending on the complexity of the form.

Effective Date: Once the patient/guarantor signs this agreement, they agree to all the term and conditions contained herein and the agreement will be in force and in effect.



PatientsName:______________________________ SSN:______________________________

Responsible Party:______________________________ Relationship:______________________________

Signature:______________________________ Date:______________________________