



GREAT WEST
Family Care PC
 Family Medicine for Children, Adolescents & Adults

14508 NE 20th Ave, Ste 102
 Vancouver, WA 98686
 (360) 574-9730

Financial Policy

Thank you for choosing Great West Family Care as your healthcare provider. The following is a statement of our Financial Policy.

INSURANCE BILLING

You, the patient, have a contract with your insurance carrier. It is *your* responsibility to know your benefits and if we are a provider for your plan. We do not guarantee that your insurance will cover the services rendered. Although we bill your insurance, complete payment is ultimately your responsibility.

We will bill your primary insurance carrier and as a courtesy bill your secondary insurance if applicable. Providing the correct billing information is the responsibility of the patient. If your insurance has not paid within 30 days, we reserve the right to make it your responsibility to follow up with them.

CO-PAYMENT

Co-pay is due at the time of service.

WORKERS COMP/ LABOR & INDUSTRIES CLAIMS

Great West Family Care does not treat or bill for occupational injury claims. Please advise the Registration Desk if your injury is work related. If you are uncertain whether your injury is the result on a work related incident, Great West Family Care will see you for the initial evaluation. If the injury is then deemed work related, we will refer you to an appropriate specialist for follow up care.

PATIENT BILLING

If you do not have insurance or it is determined that your insurance will not cover your visit, a \$100 deposit will be required at the time of service. You will be billed for the remaining balance. If you choose to pay in full at the time of service, a 20% discount will be applied to the charges.

You will receive a monthly statement showing the total amount due on your account. Payment is due within 30 days from the date of the statement. Some circumstances may warrant a payment agreement. Please contact our office to make financial arrangements.

A \$25 fee will be assessed to your account for each returned check. This fee along with the original check amount must be paid with cash, credit card or money order prior to your next appointment.

I have read, fully understand and agree to the terms of this financial policy.

 Patient Name (Please Print)

 Patient or responsible party signature

 Date