RedCedar Family Practice, LLC
Lawrence G. Cox, D.O.
James E. Blacksmith, D. O.
Jeffery J. Dunkelberger, D. O.
689 Yorktown Road
Lewisberry PA 17339
Telephone (717) 932-4050 Fax (717) 932-8072

FINANCIAL POLICY

We are committed to providing you with the best possible care. Your clear understanding of our financial policy is important to our professional relationship. Payment of office visits is due at the time of service. We do accept cash, checks, and Master Card and Visa. There is a $25 fee for returned checks. _____initial

Insurance claims will only be completed if we are given current insurance information. If current information is not given at the time of service you will be responsible for payment of services in full.

Insurance is a contract between you and your insurance company. We will file insurance claims according to our agreement with the insurance company. Remember we file claims as a courtesy to our patients. We do not charge for this service unless additional information or extra forms are to be completed. We are not responsible for errors or delays in filling out and/or submission of insurance forms. We will not become involved in disputes between you and your insurance company regarding deductibles, co pays, non-covered charges, secondary insurance, usual and customary charges, etc., other than to supply factual information as necessary. You are responsible for the timely payment of your account.

If you have any questions regarding the payment allowance by your insurance company, you are responsible to call them directly.

If your office visits are not covered by your insurance or there is a co pay for your office visit and you do not pay it at the time of service there is an extra cost of $10 for billing expense. _____initial

As a reminder, you are responsible to convey the correct insurance coverage information prior to your service. If, at a later date, it is determined that your visit was a result of a workers compensation, motor vehicle, or any other type of claim, and your regular health insurance has already been billed and has paid, you will be responsible for any monies returned to the incorrect carrier not recovered by the new carrier, plus an administration fee of $75 to rebill the proper carrier. _____initial

If in the future should an insurance company determine they were not your primary coverage at the time of service, you will be responsible for any monies returned to your insurance carrier through reimbursement request along with our cost for development, rebilling and retrieval of information at the rate of $100 an hour. _____initial

I hereby understand and agree I am financially responsible for the cost of any services, which : or may not be covered by my insurance.

Authorization to release my medical records for insurance purposes is granted by me.

In the event the member receiving these services is a minor, the undersigned parent/guardian, agrees to be financially responsible.

Responsible party signature: ______________________________

Witness ____________________ Date ____________________