VMPC Patient Payment Policy

VMPC strives to ensure a clear understanding of your financial responsibility with respect to the medical services we provide. These policies apply to all procedures and departments.

Co-Pays: We require payment of co-pays **at the time of service**, and reserve the right to refuse treatment.

No Insurance: If you have no insurance, we collect $100 for your initial office, $75 on your follow-up visit. (Note: there may be additional charges to your office visit if any procedures are required.) We collect a partial payment on elective procedures at the time of service.

Payments: We accept **Cash, Checks, Visa, MasterCard, and Discover**. VMPC will send patients accounts to collections for balances not paid after receipt of two statements unless you make payment arrangements with our billing office. We reserve the right to require payment for services to be made at or before the time of service.

Outstanding balances: We may refuse to see patients with any prior balances.In the event that your account is placed for collection, a collection fee will be added to your account that may be necessary for recovery of the outstanding balance. **In the event of an NSF check, there will be a $40 Non-Sufficient Funds charge added to the balance due.**

Cancellations: We will charge $25 if you do not call and cancel your appointment 24 hours ahead of time for all regular scheduled appointments. The charges will be waived only if the cancellation is for an emergency situation. Notification allows the doctor to see another patient who needs to be cared for that day.

Forms/Letters/Medical Records: We will charge **$25 for forms or letters** that a provider completes on your behalf. There is a fee for Medical Records based on the State of Ohio Guidelines. Patients are entitled to ONE free copy of their Medical Records.

Attestation Statement:

I have read, understand, and agree to the above VMPC Payment Policy. I understand that charges not covered by my insurance company, as well as applicable copayment, coinsurance and deductibles, are my responsibility. I acknowledge that these policies do not obligate VMPC to extend credit.
I authorize my insurance benefits be paid directly to VMPC.

I authorize VMPC to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

_____
Print Name of Patient

_____ _____
Signature of Patient (or responsible party if minor) Date