post: PO Box 4027 *visit: 737 Spokane Ave * Whitefish, Montana 59937
call: 406-730-8682 * email: info@allfamilieshealth.org * learn: www.allfamilieshealth.org

FINANCIAL POLICY

Thank you for choosing ***All Families Healthcare*** as your health care provider. We are committed to providing the best treatment possible at a fair price. Your clear understanding of our Financial Policy is important to our professional relationship. Our business office will answer any questions about our fees or your financial responsibility. Please call 406.730.8682 and ask to speak with our office manager for general questions or concerns. For billing inquiries please email billing@allfamilieshealth.org.

Your Financial Responsibilities
You are ultimately responsible for the payment on your account. Our practice will file insurance claims for all reimbursable services to both your primary and secondary insurance carriers. Please remember that you are responsible for copayments, co-insurance, deductibles and non-covered services. We accept payment by cash, credit card, or cashier's check. You will receive statements from our office for account balances that are your responsibility; this balance is due within 30 days. If the patient portion of your account is not paid in a timely manner, collection efforts will be made. Any collection agency fees or other expenses incurred to collect the patient portion of your account will be at your expense. Once an account has been sent to an outside collection agency, payment in full will be required for all services rendered from that point on with ***All Families Healthcare***.

Health Insurance
It is your responsibility to understand your insurance coverage and benefits. Our practice participates with most private insurance plans. Please provide us with your complete insurance information and bring your insurance card to all of your appointments. As a courtesy, we submit the claim on your behalf and make every effort to resolve any billing problems that arise. Your insurance requires that we collect your designated co-pay at the time of service. Please be prepared to pay these at each visit along with any outstanding balances. Referrals and Pre-Authorization: It is the patient's' responsibility to obtain referrals and pre-authorization required by your insurance carrier and accept liability for charges should your insurance carrier deny benefits.

Medicare
We will submit to Medicare for the Medicare allowed amount. You are responsible for the deductible, co-pay and co-insurance which may be billed to a secondary insurance if you have one. All patient balances remaining after Medicare and secondary insurance payment will be billed to you and will be due within 30 days.

Accidents/Travelers
We do NOT bill third party insurance for accidents, including, but not limited to Motor Vehicle Accidents (MVA); nor, will we bill travelers/international policies including, but not limited to Canadian policies, foreign exchange student policies, etc. Patients are required to pay in full at time of service. We will provide the proper paperwork needed to submit to these insurances for reimbursement.

Self-Pay
If you do not have insurance, we expect payment in full at the time of service. A discount is offered for services paid in full at the time of service.

Disputed Claims/Visits
All disputes regarding claims and visits to ***All Families Healthcare*** must be submitted in writing to either the Provider seen or the Practice Administrator. Verbal disputes regarding claims or visits will not be considered.

Authorizations

Initial_____ *I authorize the release of any medical information necessary to process insurance claims.*
Initial_____ *I authorize my insurance benefits to be paid directly to **All Families Healthcare**, PLLC.*
Initial_____ I have read, understand and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-pays and deductibles, are my responsibility and must be paid within 30 days unless other provisions are in place.

_____	_____	_____
Printed Name of Patient or Responsible Party	Signature of Patient or Responsible Party	Date