



Office & Financial Policies

We would like to thank you for choosing GulfView Medical Institute as your medical provider. To keep you informed of our current office and financial policies, we ask that you read, initial, and sign our financial acknowledgement prior to any treatment.

Insurance: Please bring your insurance card with you at the time of your appointment. For insurance plans that we contract with your carrier requires that all co-pays be paid prior to any services being rendered. The co-pay requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. If you do not have your co-pay at the time of your visit, you must provide us a written waiver from your insurance carrier specifically authorizing GVMI to waive this obligation.

Medicare Patients: We are a participating provider for Medicare Part B (Physician Services). We expect you to pay your Medicare deductible and/or any services provided but not covered by Medicare. We will bill Medicare and your supplemental insurance directly.

Medicaid Patients: We are not a participating provider for Medicaid patients. We expect you to pay the portion that your primary insurance doesn't cover. Questions regarding your individual benefits should be addressed with your caseworker.

No Insurance: Payment will be due at the time of service. Self-pay patients will required to bring \$250.00-\$300.00 at the initial appointment. Extended payment arrangements are available if needed. Please ask to speak with our billing department to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress. If you are unable to pay your balance in full, you will need to make prior arrangements with our billing department.

Auto Accident Injury: If your injury is due to an automobile accident, we request that you provide us with any information that will assist us in getting your medical claims paid. This information may include a copy of the police report, a copy of your auto insurance policy, names and information of other parties involved. Payment for any services that we provide will be your responsibility.

Canceled Appointments: If you are unable to keep your scheduled appointment, please call our office within in 24 hours prior to reschedule your appointment as this will enable us time to use your slot for another patient.

Return Checks: A \$35.00 charge will be added to your account for any check returned by your bank for any reason.

Disability or Insurance Forms: There may be a charge of \$25.00 for the completion of medical forms. Pre-payment is required prior to the form being completed. Please allow 5-7 business days for the completion of these forms. If you would like the forms mailed or faxed to you or your insurance company, please provide the request in writing at the time of payment.

Medical Records: GVMI charges \$1.00 a page for the first 25 pages and \$0.25 thereafter for copies of your medical records, and a reasonable fee for the actual cost of mailing, shipping, or delivery. Records are retained until payment is received. We only release records for visits and tests done at our facility.

Minors: If the patient is a minor, he/she must be accompanied by Parent/Legal Guardian for each office visit. Minor Consent must be completed and signed by Parent/Legal Guardian.

Missed Appointments: GVMI requires 24-hour notice of appointment cancellation. Appointments missed that are not previously canceled may be charged a fee of \$20.00.

Outstanding Balance Policy: It is our office policy that all past due accounts be sent two statements. If payment is not made on this account, a letter will be sent to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and result in possible discharge from the practice. In the event an account is turned over to collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs. Regardless of any personal arrangements that a patient may have outside of our office, if you are 18 or over and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

Billing Information

As a courtesy to our patients we will file your insurance claims from our office. In order to do this we will require information from you. We ask that at the time of making your appointment, you inform the customer service representative of the type of insurance you have. Additional information will be required for those injuries or illnesses that are a result of a work, auto accident, or if your case is under litigation.

We will need all of your demographic and insurance information prior to your appointment. We ask that at the time of your appointment you bring your insurance card and a photo ID as well as any other information that will assist us in making sure that your claim is filed correctly.

At the time of service you will be responsible for all fee that are not covered by your insurance, including co-pays, co-insurance, deductibles, and non-covered services or items received. For your convenience we accept cash, check, and all major credit cards.

Although we are contracted with several insurance companies, it is your responsibility to make sure that our provider is in your plan. Also, if your insurance requires a referral for any services or products it is your responsibility to obtain the correct referral for those services. It is your responsibility to know your insurance.

Although we file your insurance forms, payment for your medical services is your responsibility. We will assist you in any way we can to help make this process as smooth as possible. We offer as a courtesy verification of your insurance benefits, however, this is only a quote given by your insurance company. Information may vary from the verification obtained to the actual processing of your claim. It is your responsibility to know your plan benefits.

I acknowledge financial responsibility for services rendered by GulfView Medical Institute. I understand that I am responsible for prompt payment of any portion of the charges including deductibles, co-pays and co-insurance. My signature authorizes GulfView Medical Institute to file claims on my behalf and assigns all medical rights and benefits due for these services.

Printed name: _____

Signature: _____ Date: _____