Riverside Family Physicians
Your wellness is our business
4310 Orange Street, Riverside, CA 92501
4244 Riverwalk Parkway, Suite 150, Riverside, CA 92505
TEL: 951.781.6335 FAX: 951.781.6365
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PATIENT FINANCIAL POLICY

[*Patient Name*: _____ *Patient Date of Birth*: _____]

Thank you for choosing Riverside Family Physicians, APMC, as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of your Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies or your responsibilities.

RETURNED CHECKS POLICY

There is a **$25.00 fee** that will be applied to your account for all returned checks. After two returned check events from you the group will no longer be able to accept checks as a valid form of payment with alternative forms of payment being (a) cash or (b) credit/debit card with proper identification.

Please initial here_____acknowledging you read, had an opportunity to ask questions and understand the above.

DELINQUENT ACCOUNTS POLICY

Should your account become 60days delinquent finance charges of 10% per month may be added to your bill. Services may be discontinued and your bill may be turned over to a collection agency if your account becomes delinquent. It is our office policy that all past due accounts be sent 2 statements. If payment is not made on this account or you have not called to make payment arrangements, the account will be sent to the collection agency and/or attorney, as well as possibly discharged from the practice. Should that happen you will be responsible for payment of all legal and other applicable collection costs. Additionally, we will not be able to continue your care unless the balance is paid in full.

Please initial here_____acknowledging you read, had an opportunity to ask questions and understand the above.

CO-PAYMENTS POLICY

All co-payments are due at time of check-in unless prior arrangements have been made with one of our Business Office staff members. If you did not make prior arrangements with our Business Office and are unable to pay your co-payment your options are to:

a) Reschedule your appointment (**Cancellation Policy** applicable here),
b) Authorize your co-payment be billed to you with a **$10 processing**,
c) Confirm office has sufficient time to see you later in the day after you have secured your co-payment

Please initial here_____acknowledging you read, had an opportunity to ask questions and understand the above.

FORM COMPLETION POLICY

For patient requesting forms to be completed by our practice there will be a fee of **$10 per page**—*with few exceptions*—in addition to applicable office visit fees. For example, if you request your physician to complete a two-page, double sided form for your employer the form completion fee charge will be $40, in addition to applicable office visit fees.

Please initial here_____acknowledging you read, had an opportunity to ask questions and understand the above.

MEDICAL RECORDS RELEASE POLICY

It is the policy of Riverside Family Physicians, APMC to charge for requested copies of a patients' medical records. A reasonable fee may include actual costs for copying, labor, mailing, shipping or delivery. A medical release form must be properly completed prior to medical release request being processed.

Please initial here_____acknowledging you read, had an opportunity to ask questions and understand the above.

I, _____, have read, understand, and agree to the provisions of this Patient Financial Policy Form. I understand that this policy replaces any prior financial policy signed and will be strictly enforced.

Authorization for treatment and financial agreement

I authorize treatment for myself and/or patient. I agree to pay fees and charges for such treatment at the time they are incurred, unless previous arrangements have been made in advance. If I have health insurance I agree to bring my health insurance card and government identification to every visit, as well as confirm that I am eligible for coverage on the date of visit. I authorize Riverside Family Physicians, APMC to use any and all medications and/or anesthesia deemed necessary during the course of treatment up to and including emergency services.

Authorization to pay benefits to physicians

I hereby authorize payments directly to Riverside Family Physicians, APMC for Medical/Surgical Benefits otherwise afford me. I authorize Riverside Family Physicians, APMC to relates any/all medical records to my insurance company which are deemed necessary to secure payment for services rendered.

_____	_____	_____	_____
Patient/Guardian Signature	**Patient/Guardian Name**	**Date of Birth**	**Date**

_____	_____	_____
Witness Signature	**Witness Name**	**Date**