



6615 DELMONICO DRIVE
COLORADO SPRINGS, CO 80919
719.590.9494 • Fax 719.594.9761

325 SECOND STREET
MONUMENT, COLORADO 80132
719.481.3031 • Fax 719.481.0516

www.strodefamilypractice.com

FINANCIAL POLICY AGREEMENT

To prevent any misunderstanding, we would like to inform you of our financial policies prior to your services.

To help us provide the best service possible, complete, accurate, up-to-date insurance information is a necessity with each visit to the office. Insurance benefits are happily accepted, but the “co-payment” is, of course, your responsibility and *DUE AT THE TIME OF SERVICE*. Co-payments may also be warranted for specific treatments. Deductibles and the amount not covered by your insurance will be billed to you and due at that time. We do our best to let you know what your approximate portion will be for services and/or treatments, but it is always an *ESTIMATE* and is not a guaranteed amount. The clinic may add a FINANCE CHARGE to the account at a rate of ONE AND ONE HALF PERCENT (1-1/2%) per month of the unpaid balance, which is an ANNUAL PERCENTAGE RATE OF EIGHTEEN PERCENT (18%). We accept cash, checks, Visa, MasterCard, and Discover for payment. The clinic’s payment schedule is as follows:

- \$100.00 balance or less: Entire balance due
- \$101.00 to \$500.00 balance: \$100.00 minimum monthly payment
- \$501.00 to \$1,000.00 balance: \$200.00 minimum monthly payment

Strode Family Practice cannot carry accounts receivable balances greater than \$1000.00. Arrangements would need to be made to pay any balance greater than \$1000.00 in full.

In order to help keep our fees as reasonable as possible, we ask our patient’s cooperation in keeping their appointment as scheduled. Missed appointments not only delay necessary treatment for yourself, but also keep other patients in need of medical care from receiving timely treatment. If you miss your appointment and do not call to cancel or reschedule at least 24 hours in advance of the appointment there will be a fee of \$25.00 billed to you. If you miss three (3) scheduled appointments you may be discharged from the practice.

We request that our patients give us the courtesy of 24 hours notice prior to changing an appointment. We thank you in advance for working with us in scheduling appointments that you will be able to keep.

If there is any way we can assist you regarding our financial policies, please talk to our Insurance and/or Billing Department Staff *PRIOR* to your service.

We appreciate the opportunity to serve you, and thank you for choosing us to take care of your medical needs.

Assignment of benefits: Patients hereby assign to Strode Family Practice, and/or its representatives and providers all medical benefits (including Medicare) and authorize direct payment of such benefits to Strode Family Practice or its provider of services. Patient accepts responsibility for payment of all charges, regardless of insurance coverage.



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1. Do not sign this consent before reading it.
 2. You are entitled to an exact copy of the consent you signed.
 3. These conditions shall be valid and shall remain in effect for all services provided by Strode Family Practice

Patient/Responsible Party Signature

Date

Please print your Name

FOR MEDICARE PATIENTS ONLY

Patients hereby assign to Strode Family Practice, and/or its representatives and providers, all medical benefits from Medigap carrier _____ and authorizes direct payment of such benefits to Strode Family Practice or provider of services.

Patient/Responsible Party Signature

Date

Please print your Name
