1108 W. Indian School Road
Suite B, Phoenix, AZ 85013
Phone: 602.773.5600
Fax: 602.773.5600

12020 S.Warner Elliot Loop
Suite 101, Phoenix, AZ 85044
Phone: 480.751.1900
Fax: 480.779.6289

Financial Policies Form

Please take time to Read, Sign and Date this Financial Policies form. If you feel that you need additional information or explanation regarding these policies, please refer to our office brochure and our billing specialist will be glad to answer any questions.
We are contracted with many insurance plans. Under these plans the patient or responsible party may be required to pay deductible, co-pay, co-insurance for non-covered goods and services.

All Co-Pays and Deductibles are due at time of service. We do not accept personal checks.

It is your responsibility to know your insurance plan benefits. Routine physicals, immunizations, well-child checks, certain lab tests, procedures and prescribed medications, etc may not be covered. If the service is not covered by your plan, payment is due at time of service. We encourage you to contact your insurance carrier ahead of time and verify appropriate coverage. We will also require proof of insurance in the form of an insurance card, or in case of a new policy a copy of the enrollment form specifying insurance company name and phone number, employer and his/her phone number, insured employee name, date of birth and social security name.

If you are cont contracted with your insurance plan, you must pay in full at time of service. A copy of your driver's license will be taken. You will be given a copy of our charge slip to submit to your insurance for reimbursement purposes.

We submit our services to your insurance company as a courtesy to you. However, you are responsible for the balance of the account and any portion not paid by your insurance, and you will receive a statement detailing the activity and balance on your account. You may need to contact your insurance carrier to find out why they have not made payment. Outstanding balances will be paid in full before scheduling another appointment.

There will be a $50 charge for any letter written by our providers on behalf of the patient.

I have read, agree and understand the above policies of Phoenix family medical Clinic, and by signing below I accept these responsibilities:

_____ _____

Patient Signature Date Patient Name