

Thank you for choosing Northern Michigan Regional Health System physician practices for your healthcare needs. We are dedicated to providing you with quality, affordable care and excellent customer service. As part of our professional relationship, it is important that our patients fully understand our financial policy.

**All patients must read and sign this form prior to receiving services.**

## Insurance

- As a patient you are required to present a current insurance card and photo ID at each visit.
- We participate in most health insurance plans, including Medicare, Medicaid, Blue Cross Blue Shield and Priority Health. However, we encourage all patients to confirm that their physician is listed as a practicing provider by their insurance company prior to an appointment.
- As a patient you are responsible for any deductibles, co-insurance, co-payments or non-covered service charges at the time the service is rendered.
- We will file a claim to the insurance company identified by you at the time of service. If the insurance denies a claim for any reason, the balance becomes your responsibility and will appear on a monthly statement.

## Billing

- You will receive a statement (sent to the billing address you provide) notifying you of any balance you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact the Central Billing Office (231.487.7129) within 30 days after the receipt of the statement.
- Payment is expected in full upon receipt of the statement. Our offices accept payment by credit/debit card, cash, or check. If you are unable to pay the balance in full, you must contact the billing office to discuss a payment schedule.
- Failure to make payment arrangements or to keep your account current may result in you not being able to receive services in our offices. Please be aware that if a balance remains unpaid, your account will be referred to a collection agency and you and your immediate family members may be discharged from the practice.

I hereby acknowledge that I have read this document and understand my financial responsibility for services provided, and agree to abide by the above guidelines.

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Signature of Patient / or Legal Guardian      Date      Relationship to Patient (if applicable)