



SACO RIVER MEDICAL GROUP

Financial Agreement

Thank you for choosing the Saco River Medical Group. Your health and well being is important to us. We are dedicated to being your medical home in a caring primary care practice. Please read the policies below in order to understand your financial responsibilities for your medical care.

I agree and understand to the following administrative policies:

- My account is to be kept current. **Payment on accounts with outstanding balances is expected at every visit.**
- If I am a self-pay or sliding-fee scale patient, payment in full is due at the time of service.
- Returned Check Fee: If a check is returned due to insufficient funds, a fee of \$25.00 will be charged to my account.

I agree and understand to the following policies regarding insurance:

- It is my responsibility to inform Saco River Medical Group of any changes to my insurance policy so that my coverage can be verified prior to my appointment.
- I understand it is my responsibility to familiarize myself with my insurance benefits and coverage.
- I understand that Saco River Medical Group will submit my insurance claim as a courtesy for reimbursement.
- I understand that not all services provided to me will be covered by my insurance plan, and that, regardless of my benefits or coverage, I am responsible for any unpaid amount by my insurance.
- It is the policy of Saco River Medical Group to accept co-payments on the day of my appointment unless prior financial agreements have been made with the billing department.

If you have any questions in regard to this policy or the above information, please do not hesitate to ask us.

I have read and agree to the above terms of the Financial Agreement and agree to meet all financial obligations related to my medical care.

Patient Name

Name of Parent/Guardian

Signature

Date