Patient Financial Policy

LEE MEMORIAL
HEALTH SYSTEM

Thank you for selecting Lee Physician Services as your health care provider. Lee Physician Services payment policy is designed to support Lee Memorial Health System's goal of providing the highest quality of health care.

- ☞ You will be responsible for payment of all fees at the time of service, if we are not an approved provider for your insurance plan. As a courtesy, we will file your insurance claim.
- ☞ Full payment for patient's out of pocket (co-payments, coinsurance & deductible) are due at time of service. (The parent or guardian accompanying a minor is also responsible for all out-of-pocket expenses at the time of service.)
- ☞ We accept Visa, MasterCard, American Express, Discover, personal checks, travelers checks & cash.
- ☞ Patient information and proof of insurance are required prior to being seen by the provider. If you are unable to validate proof of insurance, you will be responsible for full payment at time of service.
- ☞ If your insurance denies payment for non-participation of the provider you are seeing, you will be fully responsible for rendered services.
- ☞ It is your responsibility to inquire as to reason for non-payment if your claim is denied. This balance will become your responsibility for payment in full.
- ☞ Your employer or group plan administrators can address coverage issues. We cannot act as a mediator with the carrier or your employer. **It is your responsibility to know which service and diagnostic facilities (i.e. lab tests, x-rays, etc) are covered by your benefits.** We strongly encourage you to be as familiar as possible with the coverage and limitations of your healthcare insurance, to minimize the chance of unexpected problems.
- ☞ Any balances due by the patient are expected within 30 days.
- ☞ In the event you have questions regarding your bill or need assistance in making payment arrangements, the Claims Management customer service department can be reached by calling (239) 278-3903. Lee Physician Services strives to meet personalized needs ofour patients. Please understand that payment of your bill is part of your treatment. We are here to assist you.

I have read the above financial policy of Lee Physician Services and understand my financial responsibility as a patient.

Signed: ____ Date: ______________

Patient Name: ____ DOB: ______________

White – Medical Record   Canary – Patient   FM# 0453 3/05