



## FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our payment plan.

### **ALL PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE**

This includes any copayments and outstanding coinsurance/deductibles from participating insurance companies. If you do not have insurance you will be expected to pay at the time of service. Olympic Medical Center accepts cash, checks, VISA, and MasterCard. There will be a \$25.00 service charge for any returned checks.

#### **INSURANCE:**

We bill participating insurance companies for you. You are expected to pay any copayments and any outstanding deductibles/coinsurance charges at the time of service, unless other arrangements have been made in advance. If within 45 days of the charges being sent to your insurance company we have not received payment, you will be expected to pay the balance in full.

We will bill your secondary insurance if you have provided that information with the front desk.

If you need assistance or have questions, please contact the Billing Coordinator between 8:00 a.m. and 3:00 p.m., Monday through Friday at (206) 782-1133 ext 123.

#### **REFUNDS:**

Overpayments to patient accounts will be credited to the account to be applied to the next visit or a check will be sent within 30 days from Northwest Hospital and Medical Center.

#### **MANAGED CARE:**

If you are enrolled in a managed care plan (i.e. HMO), you must receive a referral from our office before seeing a specialist. **NO RETROACTIVE REFERRALS WILL BE GIVEN.**

#### **MISSED APPOINTMENTS/LATE CANCELLATIONS:**

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-cancelled appointments. Excessive abuse of cancelled appointments may result in a discharge from the practice.

**I have read and understand the Olympic Medical Center Financial Policy. I agree to assign insurance benefits to Olympic Medical Center whenever necessary.**

**Signature of insured or authorized representative:** \_\_\_\_\_

**Date:** \_\_\_\_\_