KHATIB
FAMILY PRACTICE

Financial Policy

Thank you for choosing **Khatib Family Practice** as your healthcare provider. We are committed to providing the best medical care possible. Please understand that payment of your bill is considered an important part of your treatment. The following statement outlines our **financial policy**. Please read carefully and sign.

Patient Responsibilities

- **Accurate and complete personal and insurance information** must be provided before seeing the doctor.
- **Co-pays and deductibles** are due **at the time of service**.
- We accept **cash, Visa, MasterCard (including debit), American Express, and Discover**.
- **No personal checks are accepted.**

Insurance Policy

We participate in **most insurance plans**. However, the **primary subscriber** is **personally liable** for any balances not covered by insurance.

- If you do **not** have a current insurance card or **we cannot verify eligibility** at the time of service, you will be considered **self-pay** and responsible for full payment.

Usual & Customary Rates

We are committed to providing the best medical care and charge **reasonable and customary fees** for our region and specialty.

- If your **insurance uses a different fee schedule**, you are responsible for the **remaining balance**.

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Billing & Payments

- **Statements are sent out monthly**.
- Accounts **over 30 days past due** will be sent to a **collections agency** which may affect credit score and incur additional penalties.
- Any **fees incurred from collections** will be added to your balance.

Co-Pay Balances

- **Co-pays** are collected **at the time of service**, as required by insurance company contracts.

Payment Arrangements

If you are **unable to pay your full balance**, the following **minimum monthly payment arrangements** apply:

- **Balances under $300: $50 minimum** per month.
- **Balances over $300: $100 minimum** per month.
- Payments must be made **on time**.
- **Payments more than 30 days past due** will be sent to **collections**, and any additional fees will be added to your balance.

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Patient Acknowledgment

I have read and understand the **Financial Policy**. I agree to comply with its terms.

Patient Name: _____
Date of Birth: _____

Patient/Responsible Party Signature: _____
Date: _____
