FINANCIAL POLICY

BRANDYWINE MEDICAL ASSOCIATES

Thank you for choosing us as your Primary Care Provider. We are committed to providing you with a consistently high standard of care and pleased to discuss our services at any time. Your clear understanding of our Financial Policy is an important part of our professional relationship. We request that you take time to review it and sign our acknowledgement form prior to receiving treatment from us. If you have any questions about our fees, financial policy or your responsibility, please ask to speak with our Practice Manager.

Our practice is committed to providing the highest standard of care for our patients and our fees are considered usually the customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of "usual and customary rates."

Full payment is due and expected at the time of service. You may make your payment by cash, check, or credit card. It is our policy to charge a fee of $35 for any returned check.

Your insurance coverage is a contract between you and your insurance company. We will file an insurance claim as a courtesy to our patients; however, this does not release you of your financial responsibility. If your insurance company has not paid your account within 60 days from the time of service, the outstanding balance automatically becomes your responsibility. We will not be involved in the disputes between you and your insurance company regarding deductibles, co-pays, covered charges, etc. other than to supply factual information as necessary. Please be advised that some and perhaps, all of the services provided to you may be considered a non-covered service or medically unnecessary by your insurance. In this case, you will be financially responsible for the timely payment of your account. For those who request it, we provide an estimate of the cost of the service to be performed, if such information is available to us.

As a patient, it is your responsibility to advise us if you have a change in your demographic and insurance information. To protect our patients against identity theft, we require you to present a valid health insurance card and a photo identification card, preferably a state issued one at each time of visit. We will also need a proof that would reflect any demographic or insurance information change. All copays and balances are due at time of visit and will be collected before you see the physician. We reserve the right to take lawful actions including terminating our physician-patient relationship for nonpayment.

Any minor patient must be accompanied by an adult representative who has assumed financial responsibility for the minor patient.

You must notify us at least 24 hours in advance if you need to cancel your appointment. We charge a "no show fee" of $30.00 for established patients, $60 for physical exams, and $60.00 for new patients if we are not notified at least 24 hours in advance.

We are mandated by federal regulations to obtain a written authorization for release of medical information. We follow the guidelines set by the Delaware Secretary of Department of Health for charging for reproduction of medical records. Our fee schedules are as follows:

Amount charged per page for pages 1-10.....	$2.00
Amount charged per page for pages 11-10	$1.00
Amount charged per page for pages 21-60	$ .90
Amount charged per page for pages 61 and above	$ .50

In addition to the amounts listed above, charges will also be assessed for the actual cost of postage, shipping and delivery of the requested records. Payments of all costs are required in advance of release of the records except for records requested to make or complete an application of disability benefits program. We understand that due to a medical condition, you may file an insurance or disability form. Please be aware that we charge $30-$50 per form.

Thanks for taking time to review our financial policy. Please let us know if you have any questions and concerns.

I hereby acknowledge and agree to the financial policy mentioned above:

Patient Signature: _____ Date: _____