Emerald Coast Family Medicine

Dr. T. Castaneda, M.D.

143 S. John Sims Pkwy Valparaiso, FL 32580

Patient Financial Policy

In order to prevent confusion between our patients and this practice, we are notifying you of the following financial policy. If you have any questions, please discuss them with our billing department at (850) 623-2948 or the office manager. It is our goal to provide the best possible care and service to you and your family and a complete understanding of our financial policy is an essential element of the care we are able to provide.

- Payment is due at the time of service unless other arrangements have been made in advance. For your convenience, we accept cash, check, debit, MasterCard, Visa, American Express, or Discover. A fee of $30.00 will be charged for any returned checks. If an adult other than the parent or guardian accompanies a child for their appointment, we will look to that person for payment at the time of service.
- Our practice participates with many insurance companies and accepts assignment of benefits. We will bill the plans with whom we have this agreement for any services rendered to you and will only require you to pay any applicable co-payment and/or deductible at the time of service.
- If you have an insurance policy with whom we do not participate, we will file a claim as a courtesy to you. However, your insurance policy is a contract between you and your insurance company. If your insurance does not pay the practice within 90 days we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.
- All insurance policies are not the same and do not cover all services. In the event your insurance policy determines a service to be “not covered”; you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- Hospital services provided by Dr. Castaneda are billed separately from the hospital charges and will be billed to your insurance company. Any balance due is your responsibility and we will bill you for these services.
- In order to provide the best service possible to all of our patients, please notify our office 24 hours in advance if you will not be able to make your appointment. No show appointments will be charged $25.00 for a regular office visit, $50.00 for a complete physical, and $100.00 for a procedure.

I have received a copy, read and understand the financial policy of this practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice and notice of such amendments will be posted at the practice.

____

Signature of Parent/Responsible Party Date

Name of Patient:____