Financial Policies

Thank you for choosing Pulmonary Associates of Richmond, Inc. We are committed to your health and to offering exemplary service. The following is a statement of our Financial Policies. We require all patients, to read and sign this document prior to treatment being rendered.

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECK, CREDIT CARD (VISA, MASTERCARD, AND AMERICAN EXPRESS) AND DEBIT CARDS.

Insurance

We require co-payments be made at the time of service. We will bill your insurance company as a courtesy to you. In order for us to properly file your claims, we must have the most up-to-date information regarding your insurance coverage. For this reason, you may be asked to present your insurance card(s) at each visit. I hereby authorize my insurance benefits to be paid directly to Pulmonary Associates of Richmond, Inc. and acknowledge that I am financially responsible for any unpaid portion of my bill.

Referrals

Some insurances require subscribers to have a referral from a primary care physician prior to being seen by a specialists (such as a Pulmonologist). If a referral is not obtained at the time of service, the services rendered will be the financial responsibility of the patient.

Missed Appointments

Unless cancelled at least 24 business hours in advance, our policy is to charge a fee for a missed appointment. The no show fee for follow up appointments is $50, for new patients it is $150, and for sleep studies it is $250. Effective 11-1-2022 No show for Sleep Studies increases to $500.00

Fees for Letters and Forms

Your physician will fill out forms that you may need (e.g., workers compensation forms, FMLA forms, etc). Please be advised that due to the time required to dictate letters/complete forms there will be a $25.00 fee for this service. Those costs are not covered by the insurance companies.

Returned Checks

In the event that a check is returned for insufficient funds, a $38 returned check fee will be added to your account.

Collection Fees

In the event that your account becomes delinquent, I will be responsible for all cost of collection

including administrative charges and attorney's fees of 33.3% plus court costs and interest at the rate of 12% annually.

I have read the above Financial Policies and I understand and agree to them.

_____ _____

Signature of Patient or Responsible Party Date

Written Acknowledgement of Privacy Practices

Our Notice of Privacy Practices Provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our Notices, you may obtain a revised copy.

I have received a copy of the Pulmonary Associates of Richmond, Inc. Notice of Privacy Practices. I understand that I may ask questions if I do not understand any information contained in the Notice.

_____ _____

Signature of Patient or Responsible Party Date

Print Patient Name: MERGEFIELD PName «PName»

Patient ID#: MERGEFIELD PNumber «PNumber»