Moon Valley Health

Personalized Primary Care

Payment Policy Update 2020

1. Payment is due at the time of service. We accept cash, checks, and all major credit cards.
2. All co-payments must be paid up-front. Failure on our part to collect copayments from patients can be considered insurance fraud. All deductibles must be paid in full. Failure on our part to collect deductibles from patients can be considered insurance fraud.
3. If uninsured or not insured by a plan we accept, payment in full is expected.
4. Not all insurance plans cover all services, such as routine physicals, bloodwork, immunizations, etc. Please contact the insurance company with any questions regarding coverage. The patient is responsible for services not covered by insurance.
5. If insurance coverage changes, it is the patient's responsibility to provide new information before seeing the doctor.
6. Accounts 60 days past due will be turned over to collections. Any costs associated with collections will be the responsibility of the patient. This will also result in discharge from the practice.
7. A missed visit fee of $25.00 will be charged if appointments are not canceled within 24 business hours. Visits will not be rescheduled until this fee is paid.

Outstanding balances are due upon receipt of a statement from our office.

I have read and understand the practice's payment policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature _____ Date _____

Printed Name _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form, you acknowledge that Peter J Reed DO, PC has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service with us after April 14, 2003.If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

[ ] I have received Moon Valley Health Privacy Notice/ HIPAA or have been informed that the notice is available in paper form in the office or online.
[ ] Moon Valley Health has given me the chance to discuss my concerns and questions about the privacy of my health information.

_____ _____

Patient's Signature Date

_____

Printed Name