Financial Policy

Thank you for choosing Arkansas Health Group as your health care provider. We are committed to providing you with the best possible care. Your clear understanding of our Financial Policy is important to our professional relationship. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. Please ask if you have any questions about our Financial Policy, fees, or your responsibility.

Insurance Coverage
Your insurance coverage is a contract between you and your insurance company. We are not a party to that contract. If you have insurance, we will help you receive maximum benefits. If we accept your insurance, you must pay any co-payment and/or estimated coinsurance and deductibles prior to seeing the provider.

In the event we accept assignment of benefits, the patient is still ultimately responsible for all charges.

Usual and Customary Rates
Our practice is committed to providing the best treatment for patients and we charge what is usual and customary for our area. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, etc., other than to provide factual information as necessary. You are responsible for the timely payment of your account.

Motor Vehicle Accidents
In the event you are involved in a motor vehicle accident, you are expected to pay for services when rendered. We will gladly provide you with all the necessary paperwork to file your insurance claim with your carrier.

Nonpayment
If your account is over 60 days past due, you will receive a letter that you have 20 days to pay your account in full. If the balance remains unpaid, we may refer your account to a collection agency, and you and your immediate family members may be discharged from this clinic.

Missed Appointments and Paperwork Completion
The clinic will be charging a nominal fee for the completion of paperwork outside a scheduled visit as well as for appointments that are not kept or canceled with less than 24 hour notice.

Assignment of Insurance Benefits
I request that payment of insurance benefits be made on my behalf to Baptist Health Family Clinic – Hillcrest for any services furnished to me by any provider in this clinic. I authorize any holder of medical information about me to release any information needed to determine benefits to my insurance carrier, and where applicable, to the Center for Medicare and Medicaid Services and its agents. I further authorize the clinic or its agents to verify employment and wage data in the event collection action becomes necessary.

Signature of patient or responsible party Date

Signature of co-responsible party Date

We accept cash, check, Visa, Mastercard or Discover