

**TRINITY FAMILY MEDICAL CENTER, PA**

**Dr. Stephen E. Young**

1707 Mayo Drive  
Tavares, FL 32778

As a courtesy we will file your insurance. It is your responsibility to make sure we receive prompt payment from them. It is useful to maintain frequent contact with your insurance carrier to make sure they are paying as they should.

If your insurance denies payment on your account you will be asked to pay by check, cash or charge. If you do not pay in a timely manner, your account may be subject to a monthly late charge and turned over to collection. If you do not agree with the denial it is your responsibility to pay services rendered and take the matter up with your insurance.

Upon check-in, we will collect your co pay, uncovered services, or percent of your responsibility. Please be prepared to pay before you are seen by the doctor. Please be thorough with your insurance information if you expect us to file for you. We will need a copy of your card and your driver's license. We will not be able to see you without these items.

**TO ALL MEDICARE PATIENTS:** We will continue to participate as a Medicare provide. We will bill Medicare as well as secondary insurance, but if payment is not received from your secondary insurance within 45 days you will be notified and must pay our office the balance due. You must then contact your secondary insurance to pay you for the balance you paid our office.

**SELF PAY PATIENTS:** This category includes those people with no insurance and patients who have an indemnity plan and wish to file their own insurance. **Payment for medical services is expected on the day the services are rendered.** We accept Visa, MasterCard, checks, money orders and cash. If you will not be able to pay for our services in full, you must inform us and make payment arrangements before seeing the doctor. **(Please note: arrangements will not be made on 1<sup>st</sup> time visits).**

If your insurance is out of state (except PPO insurance) you must pay for your visit at the time of service. 95% of out of state insurance companies pay the patient and will not pay us directly (even if they tell you they will).

**If you have any questions regarding this policy please ask prior to being seen by the physician.**

\_\_\_\_\_  
**Print Patient Name**

\_\_\_\_\_  
**Print Name of Guarantor (if different from patient name)**

\_\_\_\_\_  
**Signature of Patient/Guarantor**

\_\_\_\_\_  
**Date**

**Do Not Remove From Medical Record**