His Branches Health Services

Grace Family Medicine
340 Arnett Blvd., Rochester, NY 14619
Phone: (585) 235-2250 • Fax: (585) 235-0011
Web: www.gfm3.org

Joy Family Medicine
918 N Goodman St., Rochester, NY 14609
Phone: (585) 697-0004 • Fax: (585) 697-0046
Web: www.joymed.org

FINANCIAL AND BILLING POLICY

- **Payment is expected at the time of service.** We gladly accept all Major Credit Cards, Personal Checks and cash for co-payments and balances due. If you are not covered by insurance, your balance is due at the time of service unless prior arrangements have been made with our Billing Manager.
- We do offer a Sliding Fee Scale and Payment Plan options to those who are not covered by insurance. Please ask one of our secretaries for more information.
- We are happy to file claims directly to your insurance carrier. If you use more than one policy, we will file the balance to your secondary insurance.
- Please present your proof of insurance at the time of your appointment. Without valid proof of insurance, you will be responsible for full payment of your bill at the time of your visit. It is your responsibility to update your Primary Care Physician (PCP) prior to being seen.
- Your insurance policy is a contract between you and your insurance company. His Branches Health Services is not a party to that contract. All balances are your responsibility regardless of insurance coverage.
- It is your responsibility to notify the secretary of any changes to your insurance, address, or telephone number prior to each visit. Keeping your records accurate and up to date is important in providing you with the best care.
- We understand how life can throw us a curve sometimes. If you have special circumstances and need help paying your bill, please ask one of the secretaries to help you establish a payment plan.
- A 24-hour prior notice is required for cancellations or changes to appointments. A $25 no show fee may be charged to you if we do not receive notification.

By signing below…

- I authorize direct payment to His Branches Health Services of all medical benefits otherwise payable to me/my family member under the terms of my/their insurance. A photocopy of this authorization shall be considered as effective and valid as the original.
- I have read the above information and have provided information that is true and correct to the best of my knowledge. I agree to the above terms and will notify His Branches Health Services of changes to this information.

_____
Please Print Patient or Guarantor Name

_____ _____
Please Sign Patient or Guarantor Name Today's Date