Health 1st Medical
311 West Palmetto St
Florence, SC 29501
843-662-2811 Fax: 802-400-2609

Billing Policies

Financial Policy – Payment is expected at the time of your office visit. We accept credit cards, cash, and personal checks with a valid SC driver's license. Keep in mind that your insurance policy is a contract between you and your insurance company. As a service to you we will file your insurance. If your insurance is not ohne we participate with then you will be responsible for payment in full at the time of service. If we later receive a check from your insurer, we will refund any overpayment to you. If your insurance company is one we participate with you may pay your estimated portion at the time of service. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you. **Not all insurance plans cover all all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of statement from our office.

There will be a $30 fee for all returned checks. Balances over 90 days old may be subject to collections.

Certain laboratory services are processed and billed by outside laboratory companies. Therefore, you will receive separate billing from these companies for services performed.

Disability/FMLA/Leave of Absence Forms- There will be a minimum $20 charge for form completion. This fee must be paid in advance. Our office requires 7 to 10 days for form completion. Some cases may require an office visit with the doctor.

Return Calls – All calls to the office will be responded to in a timely manner. If you call by 3pm every attempt will be made to return your call by close of business the same day. Please leave a phone number. All calls are responded to in a manner so that providers are interrupted as little as possible during the day.

By my signature, I understand the contents of this financial agreement.

Patient Signature_____ Date_____

Patient Name Printed _____ Witness_____

CONFIDENTIAL