Santa Lucia Medical Group, Inc.
Family Medicine

Financial Policy

It is our office policy to inform you of our financial policies. Please review the section below that is applicable to you.

Please make payments for your care at each patient visit. You can establish credit after paying your first five consultations or your first $300.00 our-of-pocket expenses. Payment for balance is due when you receive your bill. Statements are mailed to you every month on the 15th.

You have the responsibility to provide us with your insurance ID card before you receive medical services. As a courtesy, we will submit claims to your primary and 2ndry insurance. If the insurance does not respond within 90 days from the date of service, you will be ultimately responsible. For your records, keep your "Explanation of Benefits" that your insurance carrier sends you. You must pay all co-payments, deductibles, and services that are not covered by your plan at the time services are received. Patients are responsible to know their benefits and for informing us of any insurance termination dates. You will be charged the estimated portion you are responsible for according to our contract with your insurance plan.

If we do not participate with your insurance, you will be responsible for payment in full. Please make payment for your care at time of service. We will not be responsible for billing your services to your insurance; therefore, you may request a copy of the bill at exiting.

It is the policy of Santa Lucia Medical Group, Inc. to obtain social security numbers on all responsible parties. Also for security purposes we require identification of at least one parent or guardian.

Santa Lucia Medical Group, Inc. does not accept HMO's, Workers's Compensation injuries or work-related services, personal injuries involving third party liability, Medi-care, or Medi-cal.

Statements are mailed to you every 15th of the month. Patient due balances accrue a monthly finance charge of 1.5%. Santa Lucia Medical Group, Inc. charges a $25.00 fee for all non-sufficient funds checks.

I request that payment from my insurance company be made directly to Santa Lucia Medical Group, Inc. for any services furnished to me. I authorize Santa Lucia Medical Group, Inc. to release to my insurance carriers any information needed to determine benefits or benefits payable.

I have read and agree to financial policy, assignment of benefits, and release of information.

Patient's Name: ______________________________ Date: ___________

Patient or Responsible Party Signature:

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