



Patient Responsibility Policy

We accept most insurance plans and will gladly file insurance claims on your behalf. Ultimately, you are financially responsible for your account and are required to pay the charges not covered by your insurance plan. Please contact your insurance company if you are unsure if our provider is participating with your plan.

Patient Financial Responsibilities:

- The patient or legally responsible party is ultimately responsible for payment of services rendered.
- We will bill your insurance; however, patients are required to provide the most current insurance information at each visit.
- Patients are responsible for payment of copays, coinsurance, deductibles, and all other services provided that are not covered by their insurance plans.
- Copays and outstanding balances are due at *check-in*.
- Any outstanding balances are due *prior to being seen* for any nurse/provider visit.
- Self-pay patients: As a courtesy, the practice offers a discount to patients who do not have insurance coverage, and who pay in full at the time of service. This discount is available only on the date of service. Any past due balance must be paid prior to receiving the discount. If patient leaves before paying, patient is liable for the full cost of services without discount.
- **Cancellations must be 24 business hours** in advance or no-show fees will apply according to the No-Show policy.

Additional Information: Your provider may order testing as they deem necessary to evaluate and manage your care. On site testing is available as a courtesy; however, the lab is a separate entity from our practice and will bill independently. It is the patient's responsibility to direct questions regarding coverage for any testing directly with the testing facility and/or insurance company prior to having services rendered.

By signing below, I acknowledge that I have read and understand the Loudoun Internal Medicine Associates Financial Policy. You are aware that any outstanding balances are subject to collections if left unpaid and may lead to discharge from the practice. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name (Please Print)

Patient DOB

Patient/Representative Signature

Date

Last Updated 12/2025