Kernodle Clinic
A DukeMedicine PRACTICE

Financial Policy

Kernodle Clinic values the trust our patients place in us and we want to help our patients meet their health goals. We also want our patients to be informed about their financial obligations for our services.

1. **UNINSURED/SELF PAY**
   Patients without health insurance are expected to pay a $100 deposit on the day of their appointment.

2. **DEDUCTIBLE/CO-INSURANCE**
   We will file claims to the patient's insurance company. Patients are expected to pay up to a $100 deposit on the day of their appointment towards their unmet deductible or co-insurance. If a patient provides proof their deductible and maximum out of pocket has been met for the year, then a deposit will not be required.

3. **PAST DUE BALANCES**
   Patients are responsible for timely payment of their account balances. Failure to make timely payments on these balances may prevent patients from receiving future appointments. Should patients need to make payment arrangements or questions about their bill, they can call our billing office at 1-800-782-6945.

   Patients who have had a recent visit to the hospital emergency department and need a physician evaluation as a follow-up to that visit are expected to pay for the services Kernodle provides as indicated above.

4. **NO SHOW FEES**
   Patients will be charged a "no-show" fee if they fail to cancel their appointment at least 24 hours in advance. Three or more missed appointments may result in your being dismissed from Kernodle Clinic.

   As a *courtesy*, our office attempts to remind patients of their appointments at least two days in advance in order for them to have adequate notice to cancel if necessary; however, the patient is ultimately responsible for keeping a record of their appointments.

   If there are extenuating circumstances and you are unable to notify us 24 hours in advance, you may contact a supervisor at 336-538-1234 to request a one-time only waiver. Please note, you will be charged a "no-show" fee for future missed appointments without having canceled 24 hours in advance.

NO SHOW FEES: Office Visit = $25.00 Annual Physical / Procedure Visit = $50.00

I have read and understood the above stated financial policies 1 - 4. I agree to accept.

Signature:_____ Date:_____

Parent/Legal Guardian Signature:_____ Date:_____