THE TERRACE MEDICAL CENTRE ACCOUNT PAYMENT POLICY.  
  
We pride ourselves on giving the best possible care available, but in order to do so we need to ensure services provided are paid for so that we can continue providing this to all of our patients.

* **Payment for non-funded immunizations are to be made at the appointment, there is no exception to this.**
* **Payment for the consultation is expected on the day of the appointment unless discussed prior.**
* **At the end of the month you will be sent a statement of account. Accounts unpaid at 30 days will incur a $15 non-refundable overdue account fee every 30 days that the account remains unpaid unless a regular automatic payment is in place.**
* **Accounts reaching 90 days will incur a $30 non-refundable administration fee. If the account remains unpaid 7 days from the issue of the 90 day account, it will be lodged with our debt collection agency, and costs for debt lodgment and recovery will be added to these accounts.**
* **Repeat prescriptions, referral letters or certificates, Liquid Nitrogen, materials etc. do incur a fee each time. Prescriptions are included in a consultation, however outside of a consultation a fee is charged.**
* **We reserve the right to charge a full consult fee if a patient fails to attend their appointment or cancels their appointment without giving 2 hours’ notice.**
* **If** **you are experiencing financial difficulties, please ensure you speak with your GP, the Practice manager or accounts team as soon as possible. We are happy to work with you and may have options available to help you during this time.**
* **All services incur a fee, if you wish to dispute billing, please raise this as soon as possible. If an error has been made we will remedy this. If the charge is found to be correct, payment is expected within 7 days.**Please sign this form to acknowledge that you have read and understand this policy, and the implications of non-payment. Please advise reception if you would like a copy of this form.  
    
  I acknowledge that I have read the above policy and agree to abide by these terms of payment.  
  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  DOB:  
  Full name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_