



## Family Medicine, Geriatrics & Wellness

# PAYMENT POLICY

Thank you for choosing us as your medical provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for service rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

**1.) Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit or with-in 7 days of the date of service. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage or with-in 7 days of the date of service. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

**2.) Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraudulent. Please help us in upholding the law by paying your co-payment at each visit.

**3.) Non-covered services.** Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services at the time of service or with-in 7 days of the time of service. An advanced benefit statement must be signed by you if payment for anticipated medical services are dubious.

**4.) Proof of insurance.** All patients must complete our patient registration form before seeing the doctor. We must obtain a copy of your current and valid insurance card to provide proof of insurance. If you fail to provide us with correct insurance information in a timely manner, you may be responsible for the balance of a claim.

**5.) Claim submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Initial \_\_\_\_\_

**6.) Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 30 days, the balance will automatically be billed to you.

**7.) Nonpayment.** If your account is over 30 days past due, you will receive a letter stating that you have 14 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer you account to IC SYSTEMS, a National Collection Agency, authorized to credit report outstanding debts to the four major National Credit Agencies, litigate in a court of law (other fees may apply) and charge a service fee of \$30.00.

**8.) Missed appointments.** Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment or call at least 4 hours prior to cancel scheduled appointments.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

**I have read and understand the payment policy and agree to abide by its guidelines:**

\_\_\_\_\_  
Signature of patient or responsible party

\_\_\_\_\_  
Date

Initial \_\_\_\_\_