PRIMARY MEDICAL CARE
Financial Policy

Thank you for choosing us as your primary care 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 services 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. If you are insured by a plan we are contracted with, co-payment in full is expected at each visit. **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. **If you have a high deductible policy, you may be asked to pay a copayment of $74 at the time services are provided**. This amount will be deducted from the amount your carrier applies towards your annual deductible. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Proof of insurance. All patients must complete our daily visit slip before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

4. Claims 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. **We do not file secondary insurance policies**.

5. 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 45 days, the balance will automatically be billed to you.

6. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 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 your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

7. **Uninsured patients.** Should you find yourself to be uninsured, we offer a discount to our patients who do not have insurance. Please be advised that the discount is only good when the charges are paid at the time of service. If the charges are not paid at the time of service, the discount will be removed and payment of the full charge will be expected before the next visit. If a balance remains, you will receive a monthly statement that is due upon receipt. Any account balance over 90 days will be subject to review to collection action and discharge from practice.

8. Missed appointments. Our policy is to charge $25 for missed appointments and $75 for ultrasound appointments not canceled within 24 hours. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

9. Discharge from the practice: **We have the right to discharge a patient for consistent missed, no show or late appointments; delayed or no payment to an account; an account in collections and/or noncompliance.**

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:

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Signature of patient or responsible party **Date**