FINANCIAL POLICY PRIMARY CARE MEDICAL ASSOCIATES

Thank you for choosing ***Primary Care Medical Associates*** as your Internal Medicine Provider. We are fully committed to providing you with excellent and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it thoroughly, and sign at the bottom. This agreement will be placed into your patient chart. If you would like a copy we will be glad to provide you with one. And, of course, feel free to ask questions as they arise. Adherence to these policies will help keep your costs down.

HOW MAY I PAY? We accept payment by cash, check, Visa or MasterCard. You may pay your bill on our patient portal using Visa or MasterCard.

INSURANCE: As a courtesy for our patients, we file insurance claims for covered medical services. We participate in most insurance plans, including Medicare. If you are not insured by a plan that we do business with, payment in full is expected at each visit. If you are insured by a plan that 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. If you are self-pay, payment in full is required at the time of visit.

PROOF OF INSURANCE: We will ask for your insurance information when you make your first appointment, and will take a copy of your insurance card and driver's license at your first visit in order to verify proof of insurance. We require that you present your current insurance card upon check-in at each and every visit to ensure that our records are up to date before we file your claims. 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.

CO-PAYMENTS AND DEDUCTIBLES: We collect all co-payments, co-insurance and deductibles at the time of service. The collection of these amounts is part of your contract with your insurance company. Similarly, we are required to collect out of pocket obligations.

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. We will provide you with an estimate of these costs should the issue present itself. We collect based on this estimate at the time of visit.

MEDICARE: We gladly accept Medicare patients and will bill our services at the allowed rate.

CLAIMS SUBMISSION: We will submit your claims to your insurance company as a courtesy, and will 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. Please comply with their requests so that we can help you expedite any insurance claims. 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.

COVERAGE CHANGES: If your insurance changes, please notify us before your next visit so we can make the appropriate changes in our system to help you receive your maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will be automatically billed to you.

BILLING POLICY: Invoices will be issued after we have received any applicable insurance benefits. Invoices are due within 15 days of receipt. If we have not received payment within this time period, we will call you to collect payment before sending a second bill. If no payment is made within 15 days of the second bill, we will charge your credit card for the balance. If you are having trouble paying your bill, please contact our billing service as soon as possible and they will be happy to work with you to address the balance. If no payment arrangements have been made, accounts with balances 60 days or older will be considered delinquent and will be subject to interest.

NONPAYMENT: Patients with an outstanding balance of 60 days or more overdue **must** make payment arrangements prior to scheduling future appointments. Chronic nonpayment may result in termination of physician services – please help us to avoid this.

PATIENT REFUNDS: Patient refunds are issued on the last Wednesday of each month. Any account that has outstanding claims/balances will not be eligible for a refund until these are satisfied.

MISSED APPOINTMENTS: Appointments cancelled less than 24 hours in advance will be charged a fee: $25.00 for a 15 minute appointment, and $50.00 for a 30 minute appointment. New patients will be charged $100.00 if they do not show up to their first appointment and do not cancel on time. These fees are not covered by insurance. Please be considerate of our other patients and our physicians and cancel your appointments well in advance if not needed. These fees will be charged to your credit card without prior notice within 48 hours of the missed appointment.

CREDIT CARDS: As of May 1, 2015 we require you to keep a credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Your credit card information will be kept strictly confidential and will only be accessible through encrypted software. Payments to your card for visit fees will be processed to your card ONLY after the claim has been filed and processed by your insurer, and the insurance portion of your claim has been paid and posted to your account, in accordance with our billing policy stated above. According to your preference, we will call you 48 hours before your credit card is charged, or if you prefer, charge your balance to your credit card without a phone call if it is under $200.00. We will either mail or secure message you an itemized receipt.

We realize that temporary financial problems may affect your ability to make payments to your account. If problems do arise, please contact our billing company at 630-789-9103 for assistance.

BILLING QUESTIONS: Please call our billing company at **630-789-9103** with billing questions, to make a payment, or to set up a payment plan. They will be happy to assist you.

I have read and understand the financial policy of ***Primary Care Medical Associates*** and agree to its guidelines. I authorize the release of medical information necessary to process insurance carrier claims for treatment. I authorize medical benefits to be directly paid to Primary Care Medical Associates. I understand that I am financially responsible for any treatment not covered by my health insurance carrier.

_____ _____

Signature of patient or responsible party Date

****

I authorize Primary Care Medical Associates to charge the portion of my bill that is my financial responsibility to the following credit card/debit card/HSA card:

___ Visa ___ MasterCard ___HSA Card

Cardholder Name: _____

Signature: _____

Billing Address: _____

City/State/Zip: _____

Credit Card Number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Expiration Date: _ _ / _ _ _ _

Security Code (3 digit # on back of card _ _ _

Credit Card Preference

_____Please call me 48 hours before charging my credit card for my balance.

_____Call me if my balance is over $200.00, otherwise go ahead and charge my credit card for my balance if the amount is $200.00 or less, and mail or secure message me the itemized receipt.

*****This information will be scanned into our computer system with the credit card information blacked out for added security.

FINANCIAL POLICY PRIMARY CARE MEDICAL ASSOCIATES LTD.

Authorization for Insurance Billing

I hereby authorize Primary Care Medical Associates (PCMA) to act as my agent to file a claim directly with my insurance company, and to act on my behalf to communicate with my insurance company. I understand that I will have to pursue any grievance relating to benefits and coverage issues myself directly with my insurance company.

If the insurance company has a contract with Primary Care Medical Associates (PCMA), I hereby authorize the insurance company to make any payments directly to PCMA which would otherwise be payable to me for services rendered by my provider at PCMA. I understand that I am responsible to pay non-covered services.

I hereby authorize PCMA to release to my insurance company any information acquired in the course of my treatment necessary to process insurance claims.

Authorizations expire one (1) year from date of signature.

_____ _____

Patient Name Date of Birth

_____ _____

Signature of patient or responsible party Date