Zetter HEALTHCARE
Management Consultants
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717.691.7100

FINANCIAL POLICIES AND PROCEDURES

At [Name of Practice], we believe that all patients who are rendered care at this office deserve the best medical care that can be provided. In order for us to provide you with the highest quality medical care and current technology, we must insure that we are able to meet the expenses necessary to operate this facility. To ensure that these expenses are met, we provide you with this Agreement regarding our financial policy and your agreement to pay for services provided. Please sign and date this Agreement on the last page to indicate you accept these terms.

PAYMENT AT TIME OF SERVICE, FEES AND COLLECTIONS

Your insurance policy is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance carrier. We do provide your insurance carrier with information regarding your diagnosis and treatment. We do not get involved in such matters as disputes regarding deductibles, copayments, non-covered charges and "usual and customary" charges. If your insurance carrier does not provide payment within 40-60 days after treatment, you will be responsible for payment. You are responsible for timely payment on your account. We require that you pay any amount not covered by your insurance such as deductibles and copayments under your policy on the day of service. If your plan requires you to pay co-insurance, you will be required to pay that. [Name of Practice], is required in accordance with its contract with your insurer to collect from you deductibles and copayments. We will determine your copay and how much of your yearly deductible under your policy has been met for the year. If you are unable to pay your copayment at check-in, another appointment will be made for you. Any additional payment owed will be collected in full at the time of service. If needed, we will work with you to arrange a payment plan.

It is your responsibility to provide us with your current insurance card and photo identification at every visit so that we may bill the insurance company in a timely fashion. It will be reviewed or copied every time you are here for a visit, no matter how frequently you are seen. If a claim is rejected because your insurance does not cover the type of service rendered, you will be held responsible for the outstanding balance. **Please call the telephone number on your insurance card before your appointment and they will assist you in finding out whether the service to be provided at the appointment is covered, what your copay is and what your deductible is.** It is your responsibility to understand your insurance coverage. If your insurance does not cover the cost of your visit or procedure, you will be responsible for the charges for all services rendered.

Please educate yourself as to your coverage so that office visits, procedures, testing, and specialist referrals may be arranged to best suit your needs.

Once we determine your personal financial obligation or after your insurance company reimburses [Name of Practice], for a portion of your care, we will mail you one (1) statement. Payment is expected upon receipt of the statement. Any account past due by 30 days or more may be subject to submission to our collection agency. If your account becomes delinquent and is placed into our collection process, collection fees will be added to your balance. [Name of Practice], reserves the right to terminate any patient at this point. By signing our financial policy, you agree to pay these added fees, along with any and all costs associated with the collection of your account, including interest charges.

If a new problem is encountered, or if changes in treatment of a pre-existing condition are discussed in the process of performing a visit or exam, an additional copay and deductible payment may be incurred.

If you are seen in our office by a nurse or a medical assistant for minor medical services you may be charged a limited office visit, and applicable co-pays will be collected.

If you carry a balance on your account during the time you present at our office, a payment on your account will be required at the time unless a Credit Card is kept on file or a payment plan is in place. [Name of Practice], reserves the right to terminate any patient who misses a payment. Under unusual circumstances, we are willing to work out personalized payment schedules if you so require and can demonstrate need. We accept cash, check or credit card.

CREDIT CARD ON FILE

You will no longer receive bills from our office in the mail. We have discontinued sending patient statements. We now require a credit or debit card on file with our office. Statements are wasteful of paper, stamps, and envelopes. We need to ensure that we have a guarantee of payment on file in our office. Times are changing in healthcare, and we need to be sure that patient responsible balances are paid in a timely manner. We have to be fair and apply the policy to all patients. We have wonderful patients and we know that most of you pay your balances. Unfortunately, this is not the case every time.

You will receive a letter in the mail from your Insurance carrier that explains how much of your office visit they pay and how much you pay. This is called an Explanation of Benefits, or EOB. This letter tells you exactly, according to your health insurance coverage, how much of your health care bill is your responsibility and how much is the responsibility of your insurance to pay. We receive the same letter that you do. It arrives about 20 – 30 days after your appointment. We look at each Explanation of Benefits (EOB) carefully, and determine what your insurance has determined as patient responsibility. This is the same way we normally determine how much to send you a bill for in the mail.

We do not store your sensitive credit card information in our office. We store it on a secure website called a gateway. We access your information only on this site to process a payment. You will be required to sign a credit card on file authorization statement.

We will always work with you to understand if there has been a mistake, and we will refund you if we have made a billing error. We will only charge the amount that we are instructed to by your insurance carrier, in the letter they send to us, in the same way that we normally determine how much to send you a bill for in the mail.

ELECTIVE PROCEDURES/NON-COVERED PROCEDURES

Patients are required to pay the estimated self-pay portion of elective/non-covered procedures prior to services being rendered.

SUBMISSION OF CLAIMS

We will submit your insurance claims. However, it is important to remember that your insurance is a contract between you and your insurer. Although we file insurance claims as a courtesy to you, you are still responsible for payment of services regardless of the amount your insurance pays.

PAYMENT OPTIONS

Our office accepts all credit and debit cards. Our office also accepts valid check or cash. There will be a $50 fee for all returned checks. Once we have a returned check for you, we may require that all future payments be with cash, money order, cashier's check or credit card. We may offer to keep a credit card authorization

on file at our office. Anytime a co-pay, deductible or balance is due, we will charge the fee to your credit card which will help to keep you at a zero balance and paid up in full with your credit card on file.

CASH PAYMENT

If you wish to pay cash, you will always be provided with a receipt so that you will have a record of your payment. Please make us aware if you are not provided a receipt.

MEDICARE PATIENTS

If you have Medicare as your primary insurance carrier, but you do not have a secondary insurance, you are responsible for the deductible, copay and co-insurance at the time of service. You are also responsible to pay for services not covered by your Medicare insurance unless you have a secondary insurance. You will be required to sign an Advanced Beneficiary Notice for non-covered services.

NON-CONTRACTED INSURANCE (Out of Network)

If you have an insurance plan that we do not participate with, you may have out-of-network benefits. These benefits typically have a higher copay, coinsurance, and/or deductible out of pocket cost. You will be considered a self-pay, uninsured patient if you do NOT have out of network benefits.

UNINSURED/SELF-PAY

We offer a discount to all self-pay patients who pay in full at time of service. Payment is expected at each visit. All other ancillary, treatment and future care will be reviewed with you in order to make arrangements for payment.

MISSED APPOINTMENTS/NO SHOWS/LATE FOR APPOINTMENT

We understand that you may not be able to keep all of your scheduled appointments or might occasionally be late. Please understand that missed appointments have a detrimental impact on our practice and other patients. They also affect our ability to serve other patients in need of medical care. We understand there may be inclement weather or other circumstances that may require you to cancel your appointment. If you must cancel or re-schedule your appointment, please do so at least 24 hours in advance. Failure to cancel or reschedule an appointment at least 24 hours in advance will be considered a no-show. We reserve the right to charge you $50.00 for any no-show if permitted by law and your insurance contract. Payment of the missed appointment will be required prior to scheduling another appointment. [Name of Practice], reserves the right to terminate any patient with more than two no-show appointments upon 30 days written notice to the patient to seek medical help from another practice.

If you are running late on the day of your appointment due to unforeseen circumstances, please contact our office immediately so that we can determine whether we can see you that day or if we will need to reschedule your appointment. If you are more than 15 minutes late for an appointment, [Name of Practice], may reschedule your appointment and refuse to see you at the originally scheduled time.

REFERRALS

If your insurance carrier requires a referral or authorization for your visit, it is your responsibility to make sure that our office receives current valid authorization. If you do not have a valid referral or authorization at the time of service, we will be unable to treat you until a valid authorization/referral is obtained, and you may be sent back to your primary care physician to obtain authorization prior to being treated or full payment will be expected at the time of service. Please remember that it is your responsibility to make sure we are on your plan's provider listing. We appreciate your understanding of the ever-changing requirements of managed care plans and our position to adhere to their policies or requirements.

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FORMS AND MEDICAL RECORDS FEES

Due to the increasing costs of providing our patients with the highest standards of care, we must impose a charge for certain records and forms. It takes time for our providers and staff to retrieve and copy files, complete forms and write letters. The following charges apply:

FMLA, Disability, Corps, School forms not completed during an appointment, and Supplemental insurance forms $____

Dictated letters, extensive forms with review of medical records $_____ per page

Copies of records for personal use will be charged the allowed fee by the [Name of State or Commonwealth].

ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare, Medicaid and commercial insurance benefits be made on my behalf to the name of provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents, or any other insurer and its agents, any information needed to determine these benefits or the benefits payable for related service.

I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to [Name of Practice], for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance or this assignment.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize [Name of Practice]: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for all services provided to me by [Name of Practice]. This order will remain in effect until revoked by me in writing.

I have received the practice's Medical Authorization for Release / Disclosure of Protected Health Information / HIPAA Privacy Notice.

_____ _____

Signature Date

Patient Name (PRINT):

_____ _____

Signature Date

Name of Person Financially Responsible for Patient's Treatment (PRINT):