Our Practice Financial Policy

In order to reduce confusion and misunderstanding between our patients and the practice we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either yourself or your health coverage carrier, full payment is due at the time of service. For your convenience we will accept VISA, Mastercard and American Express.

Your Insurance

We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans for whom we have an agreement and will only require you to pay the authorized copayment at the time of service. It is the policy of our office to collect the copayment when you arrive for your appointment.

If you have insurance coverage with a plan that we do not have a prior agreement we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. The charges for your care and treatment are due at the time of the service.

In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Minor Patients

For all services rendered to minor patients, we will look to the adult accompanying the patient, authorizing treatment, and the parent or guardian with custody, for payment.

Missed Appointments

In order to provide the best possible service and availability to all our patients it is our policy to charge our office visit fee for any appointments not canceled at least one day prior. Please call us as early as possible if you know you will need to reschedule your appointment.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

______________________________
Signature of Patient or Responsible Party if a Minor          Date

______________________________
Signature of Co-responsible Party

______________________________
Please Print the Name of the Patient
CASHIER PROCEDURE

Collections at the Time of Service

· The cashier receives the encounter form (superbill) from the patient at the front desk and prices the services as well as setting up a new appointment if indicated by the physician.

· The cashier presents the completed form to the patient and tells them the total amount of charges. This is done with all patients.

    If...
    the patient has responsibility for only a copayment such as an HMO patient or an assigned claim for Medicare, the amount of the copayment should be stated and the patient should be asked, "How would you like to take care of this?". This will provide an opportunity to get cash, check or credit card.

    If...
    the patient has no way to pay either the full amount or the copayment, the cashier is to give a copy of the encounter form to the patient along with an envelope addressed back to the practice. The cashier should state a date that they could expect to have the payment back in the office.

    If...
    ... a patient asks the cashier to please bill their insurance, the cashier should state they will be happy to bill the insurance company for the patient but the practice expects all patients to pay for services at the time they are provided. This is done in order to keep the cost of office visits as low as possible. Explain to the patient that the bill will be sent out this week and the payment from the insurance will be sent directly to the patient less any copayment or deductible requirements.

· Goal: To reduce the costs of billing small copayments; to reduce the amount of money in the accounts receivable; to reduce the amount of money that becomes bad debt; to increase the cash flow to the practice; to keep the costs of office services as low as possible to patients through not having to incur bad debt and higher billing costs.
# INSURANCE PLAN BENEFITS

**Company:**

**Address:**

- 

- 

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**Phone:**

**Contact:**

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Plan Number 1</th>
<th>Plan Number 2</th>
<th>Plan Number 3</th>
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</thead>
<tbody>
<tr>
<td>Plan Name</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Street Address</td>
<td></td>
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<tr>
<td>City, State Zipcode</td>
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<tr>
<td>Prior Authorization phone</td>
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<tr>
<td>Contact</td>
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<tr>
<td>Deductible / Copayment</td>
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<tr>
<td>Referral Authorization?</td>
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<tr>
<td>In-patient Authorization?</td>
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<tr>
<td>Second Opinion?</td>
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<tr>
<td>Surgical Assist? Percentage</td>
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</tr>
<tr>
<td>Hospitals Permitted</td>
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<tr>
<td>Labs Permitted</td>
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<tr>
<td>Radiology Permitted</td>
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<tr>
<td>Other Diagnostic Services</td>
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<tr>
<td>(HMO and PPO)</td>
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<tr>
<td>Relative Value Scale Used</td>
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<tr>
<td>Medical Conversion Factor</td>
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<tr>
<td>Surgical Conversion Factor</td>
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<tr>
<td>Other Conversion Factor</td>
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</tr>
</tbody>
</table>

**Notes:** *(Indicate any special information about the company including the names of patients who are officers, managers or union hierarchy in the company).*
Patient Information Registration Form

(Please print clearly)

Patient’s Full Name:_____________________________ Age:_____ DOB:_____________ Sex: M F
Address:_____________________________________ City:______________________ Zip:_________
Home Phone:______________________ Married Single Separated Widowed
Social Security No:______________________ Driver’s License No:______________________
Patient’s Employer:__________________________________________ Phone No:______________________
Address:_____________________________________ City:______________________ Zip:_________
Occupation:__________________________________________________________________________
Spouse:_______________________________________ Social Security No:________________________
Spouse’s Employer:__________________________________________ Phone:_____________________
Address:______________________________________ City:______________________ Zip:__________
Occupation:___________________________________ Phone No:_______________________
Family Physician:______________________________ Referred By:______________________________
In case of emergency, contact (other than spouse):__________________________
Address:______________________________________ City:_____________________ Zip:___________
Relationship:__________________________________ Phone No:________________________________

REFERRAL INFORMATION: (Please tell us how you were referred to our practice)
Family Physician:_______________________________________________________________________
Health Plan:___________________________________________________________________________
Other Source:________________________ __________________________________________________

INSURANCE INFORMATION
Primary Coverage, Name of Carrier: Secondary Coverage, Name of Carrier:
Group No: ________________________________ Group No: ________________________________
Identification No: __________________________ Identification No: __________________________
Subscriber: ________________________________ Subscriber:______________________________
Effective Date:______________________________ Effective Date: _____________________________
Are you covered by Medicare? Yes No Medicare No:_______________ Railroad? __________
Are you covered by Medicaid? Yes No Please give secretary a current Medical Eligibility Form.

We ask all patients to show their insurance or managed care membership card so that we may make copies of them.

We cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient, and he or she remains personally responsible for payment. As a courtesy, however, we will prepare any necessary reports and itemizations to assist in making collections from insurance companies and will credit any such collections to the patient’s account.

PAYMENT AUTHORIZATION
I,________________________________________________________, hereby authorize __________________________; M.D. to furnish information concerning my present illness. I direct the insurer to pay, without equivocation, directly to the physician, all benefits due him as a result of this claim. Although covered by insurance, I am aware that I am personally responsible for all charges. A photostatic copy of this authorization will be used as a valid as the original.

Signature of Patient:_________________________________________ Date:________________________
PROCEDURE FOR TRACKING MANAGED CARE PLANS

Fee-For-Service

1. Record patient charges at normal billing rate.

2. Post payments from patients and the Plan to the individual ledger account.

3. Post any withhold amount as an adjustment to the patient account and a credit adjustment to an account for the specific plan.

4. Post the remaining amount as a contractual adjustment from the patient's account.

5. The patient account balance should now be zeroed out and the Plan account increased by the amount of the withhold.

6. Collection percentages can be calculated for the Plan and compared with any other financial class.

Example: A $50 charge for an office visit, a $10 copayment and a $25 payment less a $2 withhold.

<table>
<thead>
<tr>
<th>PATIENT ACCOUNT</th>
<th>Charges</th>
<th>Payments</th>
<th>Adjustments</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$50</td>
<td>$10</td>
<td></td>
<td>$40</td>
</tr>
<tr>
<td>(Payment arrives)</td>
<td>$23</td>
<td>$2 (withhold)</td>
<td></td>
<td>$15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$15 (disallowed)</td>
<td></td>
<td>$0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PLAN ACCOUNT</th>
<th>Charges</th>
<th>Payments</th>
<th>Adjustments</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Transfer withhold to Plan Account)</td>
<td></td>
<td>&lt; $2 &gt;</td>
<td></td>
<td>$2</td>
</tr>
</tbody>
</table>
Dear _______________________________,

Due to the breakdown in the physician - patient relationship, I feel you would be better served by another doctor. I will continue to provide you with emergency services only for the next 30 days.

Should you need the name of another qualified physician I suggest you contact the referral service of the county medical society.

We will send a complete set of your medical records, upon request, to another physician.

Sincerely,

Note: Check with your county medical society to see if they have adopted a uniform patient discharge. Always send a copy of this certified, return receipt requested and normal mail.

If the patient refuses the certified letter place it unopened in the chart with the seal intact.

Seal the chart and indicate in the patient ledger that the patient has been discharged.