Financial Policy

Thank you for choosing our practice. We are committed to providing you with quality and affordable healthcare. The following information answers frequently asked questions regarding patient and insurance responsibility for services rendered during your visit. Feel free to ask us any questions and sign in the space provided. A copy will be provided to you upon request.
Thanks so much for being our patient!

PAYMENTS ARE DUE AT THE TIME OF SERVICE UNLESS PAYMENT ARRANGEMENTS HAVE BEEN REQUESTED AND APPROVED IN ADVANCE. YOU ARE EXPECTED TO PAY ACCORDING TO THE ARRANGEMENT.

SELF-PAY (NO INSURANCE): We welcome self-pay patients and provide you with the same access and care regardless of your health insurance status. You will be required to pay in full at the time of service to receive the 35% discount. Otherwise, sick patients will be expected to pay a minimum of $25.00 and will be billed for the remaining balance. Patients that come in for a physical/well check will be expected to pay a minimum of $50.00 and will be billed for the remaining balance.

Insurance: As of January 1st, 2014, most people are required by law to have health insurance. Depending on your financial situation, you may be eligible for government subsidies to buy private health insurance, or you may be eligible to enroll in Medicaid. The website for further information on Medicaid eligibility is www.scthrive.org.
We participate with most insurance plans. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that make the final determination of your eligibility and dictates the amount due by the patient. You need to contact your insurance company to verify participation, benefits **(including if the insurance covers vaccinations**), and copay/deductible. If your insurance company informs us you are ineligible for benefits, you will be considered **self-pay** (no insurance), see above, or you can reschedule your visit.

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. You will need to contact them if you disagree with their determination on the payment of your claim.

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CO-PAYMENTS AND DEDUCTIBLE: All co-payments, deductibles, and co-insurance must be paid at the time of service. This arrangement is part of your contract with your insurance company. If your deductible has not been met, we expect for you to pay at least $25.00 at the time of your visit.

PROOF OF INSURANCE/ COVERAGE CHANGES: All patients must complete our Patient Information form before seeing our providers. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with this information in a timely manner, you may be responsible for the balance on your account. Some insurance companies will deny charges if filed later than 90 days after the date of service.

METHODS OF PAYMENT: We accept payment by Cash, Check, Debit/Credit Cards, HAS Cards, Cashier or Certified Check, and money orders.

PATIENT STATEMENTS: If you have an unpaid balance, you will receive a statement monthly by mail. The statement is due and payable when the statement is issued, and past due if not paid upon receipt. Balances over 90 Days will be turned over to our internal collection department and/or may be submitted to an outside collection agency with possible dismissal from the practice.

PAYMENT PLANS: We offer convenient, affordable payment plans for our in-house accounts (minimum $25 monthly payment). Please see our business office team for details.

COLLECTION FEES: Accounts submitted to the collection agency are not eligible for payment plans. All collection cost may be charged back to the account. Patients referred to the collection agency will be required to have prior approval before your visit is scheduled.

RETURNED CHECKS: Your account will be charged $25.00 for checks not honored by your bank. The check and service fee must be paid in full before your next visit.

I have read, understand, and will comply with the terms of your financial policy.

PATIENT'S NAME: ______________________________________DOB: _________

GUARANTOR'S NAME: ____

SSN OF GUARANTOR: _______________________________

SIGNATURE: ____________________________________DATE: ______________