

Connie Casad M.D.

Payment Policy

Thank you for choosing us as your healthcare 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 initial and sign in the space provided. A copy will be provided to you upon request.

Initials _____ **1. Insurance** Payment is due at time of service. If you have insurance, your co-pay and/or deductible are due at time of service. We participate in many insurance plans including Medicare. We make a reasonable effort to verify your insurance and deductible balance several days before your appointment. If your insurance card is not up to date, or if we cannot verify benefits, payment will be due at the time of your visit. Your insurance coverage is an agreement between you and your insurance company. We agree to file claims for contracted carriers per our agreement with your carrier and as a service to our patients. **If your insurance company chooses not to pay for any reason, or they choose to delay payment, you will be responsible for payment. Payments not received from your insurance company within 90 days will be billed to you.** Payment is expected within one week of receiving our billing statement. Questions regarding your statement can be answered by our billing department. Knowing your insurance benefits is your responsibility, and your insurer and your Human Resource Department can assist in securing payment of your claim.

Initials _____ **2. Co-payments and deductibles** Co-payments and deductibles are part of your contract with your insurer. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. **Because it is not possible in most cases to determine if an annual well woman exam is paid for by your insurance, you will be asked to present a credit card and sign an authorization for its use at the time of your visit for the charge allowed in our contract with your carrier. In the event that the fee for your annual exam is not paid in 45 days, we will bill you via the credit card. If insurance pays the cost of the well woman exam, the credit card information will not be used.** Please help us in upholding the law by co-operating with our staff as they determine your financial portion of medical visits.

Initials _____ **3. 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. You must pay for these services in full at the time of visit. An annual well woman exam is a general health history and a physical exam including breast and pelvic examinations. In most instances a well woman annual exam covered by your insurance does not include treatments for medical conditions including birth control, thyroid imbalance, high cholesterol, hormone therapy, or treatment for depression. We are required by insurers to document everything done during your appointment, and if your annual deductible has not been met it is not uncommon for charges from \$100 to \$200 in addition to your co-pay that will need to be paid when your time with the doctor has been completed.

Initials _____ **4. Proof of insurance** All patients must complete our patient information form before seeing the doctor. 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 the correct insurance information in a timely manner, you may be responsible for the cost of your visit at the time services are rendered.

Initials _____ **5. Claims submission** As a courtesy, we will submit claims on your behalf, 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.

Initials _____ **6. 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.

Initials _____ **7. 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 without prior consent. If a balance of this type exists, we will not be able to schedule future appointments until payment arrangements have been made. **Your account must reflect a zero balance prior to receiving additional medical services from our practice.** 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.

Initials _____ **8. Missed appointments.** Missed appointments or cancellations the day of your appointment create scheduling difficulties that are disruptive and costly to our office. Our policy is to charge \$75.00 for missed appointments not canceled within forty-eight hours before the appointment time. These charges will be your responsibility and billed directly to you and need to be paid before a replacement appointment is scheduled. Please help us to serve you better by keeping your regularly scheduled appointment.

Initials _____ **9. Returned checks.** Our policy is to charge \$35.00 for any check returned to us from your bank due to insufficient funds. If your check to us is returned, we will send a certified demand letter with the notice "this is a demand for payment in full for a check or order not paid because of a lack of funds or insufficient funds. If you fail to make payment in full within 10 days after the date of receipt of this notice, the failure to pay creates a presumption for committing an offense, and this matter may be referred for criminal prosecution". If you fail to make payment in full within 10 days 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.

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:

Signature of patient or responsible party

Date