Optimum Health Family Practice

Optimum Health Family Practice
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Optimum Health Family Practice Payment Policy

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

1. Insurance. We participate in most insurance plans, **excluding** Medicare/Medicaid. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan 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. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments. All co-payments must be paid at the time of service. This arrangement is part of your agreed-upon contract with your insurance company. Failure on our part to collect co-payments from patients, while billing insurance, can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. If your copayment is not made at time of service, a $10.00 late charge will be added to your account.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by your insurance company. You must pay for these services in full at the time of your visit (or as soon as your insurance company denies coverage of the services).

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your 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 balance of a claim.

5. 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; we are not party to that contract.

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.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. 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 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. If you have unusual financial hardship or other extenuating circumstances, please let us know.

8. Missed appointments. We charge for missed appointments not canceled at least 24 hours prior to the appointment. These charges will be your responsibility and will be billed directly to you. Please help us to serve you better, by keeping your appointment. We charge $25.00 for any appointment cancelled less than 24 hours prior to the appointment time. **If you "No Show" for your appointment without calling us, you will be charged $35.00.**

Our practice is committed to providing the best treatment to our patients. We strive to keep our prices 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**