

## OFFICE PAYMENT POLICY 2010: High Ridge Family Practice, LLC

Given the constant changes in insurance company payment policies, the following in-office policies have been established to help us continue to provide patients with the best quality medical care. These policies are not meant to offend or insult anyone, but only to serve as a guideline for greater understanding in all aspects of patient care. If you would like to discuss the office fee schedule, or these office policies please ask your doctor or the Office Manager.

1. **PAYMENT IS DUE AT THE TIME SERVICE IS RENDERED**, unless other arrangements have been made prior to the services being rendered. This includes Co-pays.
  - a. For the patient's convenience, the office accepts cash, check, money order, American Express, Visa, or MasterCard.
  - b. The patient is responsible for all **NON-COVERED SERVICE CHARGES**. (For a listing of some routine non-covered services, see Practice Fees for Non-Covered Service Notice)
  - c. A \$30.00 processing fee will be charged for all returned checks.
  
2. **ANY CHANGES** to the material on the Registration Information form must be brought to the attention of the office, **BEFORE** the doctor's visit. Failure to do so may make the patient responsible in full for **ANY & ALL** charges for services rendered. The right information is critical especially for billing proper laboratory tests that may be required and ordered. ***If this information is incorrect and not current the patient will be responsible for the bill in its entirety.*** Specifically, the patient's:
  - a. Medicare and/or Medicaid cards **MUST** be **VALID** and **UP-TO-DATE**.
  - b. Health Insurance ID cards must have **VALID UP-TO-DATE** patient ID numbers, and if a provider is required, it must have **DR. FALKOFF, HERBERT, BERKUN, ANAND, BALICHETTY or FERNANDEZ**.
  - c. Any Co-pay must be paid at the time of the visit. Co-pays not paid at the time of the visit will incur an additional \$5.00 charge.
  
3. If you have medical insurance, we will try to help you file your claims to speed up the processing. However, your insurance is a contract between you and your insurance company. Our office **CANNOT** guarantee that your carrier will pay your claim. ***If your claim with your insurance company is denied, the obligation for the payment is the responsibility of the patient.*** Our office will **NOT** enter into a dispute with the insurance carrier over the claim. We will be happy to assist wherever possible. (Note: Your insurance is **REQUIRED** by CT State Law to pay your claims within 45 days – *Conn. Gen. Stat. 38a-816(15)(B)*)
  
4. If we agree to accept assignment from your insurance carrier, the patient must sign an Insurance Assignment Agreement. Each new year **ALL MEDICARE PATIENTS** will be required to sign a new agreement.

If the insurance (HMO, PPO, or carrier other than an indemnity insurance plan) payment is mistakenly sent to the **PATIENT** instead of the **OFFICE** for services rendered, ***the patient is expected to provide payment within 10 days of receipt*** along with the Explanation of Medical Benefit. Failure to produce this payment will result in your being billed by this office, according to the policy noted below. Contractual reductions will not apply. ***The bill will be issued for full services rendered.***
  
5. Outstanding payment for **over 30** days may incur Interest Charges of 1.5% for every 30 days that the payment remains overdue, up to an annual interest rate allowable by law to 18%. Billing statements are mailed every 4 weeks. If the patient's bill remains overdue **over 60 days** the following procedure will occur:
  - a. Interest charges will continue to accrue.
  - b. Postage and office charges of \$10 will be added to the bill per pay period.
  - c. The account will be turned over to a third party for collections and a collection fee of \$25.00 plus any additional cost for third party collections will be added to the account.
  - d. All outstanding bills must be settled prior to any future care.
  
6. ***All cancellations of an office visit MUST be made within 24 hours of scheduled visit.*** Failure to do so will result in a penalty charge: the patient's office visit fee will be equal to **DOUBLE** the patient's Co-pay or \$20.00 whichever is less, except in the case of a missed Physical Exam or Comprehensive Medical Evaluation, which will result in a charge of \$50.00. This fee is **NOT** covered by insurance and payment will be the sole responsibility of the patient. You, the patient, will be billed accordingly. Please have the courtesy and respect to call our office for all appointments that cannot be kept. We work with you at every opportunity to provide you with the best quality health care.
  
7. In the case of financial hardship, this office will work with the patient to arrange a method of payment for services, with the required proof of these financial difficulties.

I have read all the information on this sheet and have completed the requested information on the registration form. I certify that this information is true and correct to the best of my knowledge. I have read and understand the Office Policies. Your signature on this form also acknowledges your understanding and Authorizes Payment of Benefits directly to this office.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_