PELICANPRIMARYCARE

PAYMENT POLICY

Thank you for choosing PELICAN PRIMARY CARE as your primary care provider. We are committed to providing you with the best possible health care. In order to better serve you, we have adopted the following payment policy:

1. INSURANCE. We participate in most insurance plans, including Medicare. 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 & DEDUCTIBLES. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.

3. MEDICARE & SECONDARY INSURANCE. Whether or not your secondary payer is a crossover, you are expected to pay the 20% co-payment at the time of service. Upon receiving payment from your secondary insurance company, we will refund you the payment.

4. NON-COVERED SERVICES. Please be aware that some, & 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.

5. 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 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.

6. 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.

7. 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 and payment will be expected immediately.

8. NON-PAYMENT. 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. A monthly interest rate will accrue to your patient balance for non-paid services. Partial payments will not be accepted unless otherwise agreed upon. 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.

9. MISSED APPOINTMENTS. If you fail to show up or cancel your appointment with less than a 24 hour advance notice, you will be charged a fee of **$25**, (**$50** for a physical). As a courtesy, a reminder call is made by our staff a day prior to your appointment, but in no way does this relieve the patient of the responsibility to fulfill their scheduled appointment.

10. PAYMENTS ACCEPTED. Cash, Check, American Express, Discover, Master Card, Visa. If your check is returned for insufficient funds, we reserve the right to add a penalty charge of **$35.00** to your account.

11. CHARGEABLE SERVICES. You will be charged for additional services you request including: medical form completion, phone and email consultations, and prescription refills (requested outside a scheduled visit).

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**