Inkwell Medical Group Financial Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. We are entering into an agreement with you, with obligations on both sides. Please read this financial policy, ask us any questions you may have, and sign in the space provided. You will be given a copy of this agreement for your records. The original will be filed in your chart.

I have received this financial policy, and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts will be referred to a collection service. If it becomes necessary to send my account to a collection service, I agree to pay for all costs and expenses, including reasonable attorney fees. I also acknowledge that I have received a copy of this financial agreement for my records.

_____ _____

Signature Date

General Information:

- In order for you to be a patient at Inkwell Medical Group, you will be asked to fill out a Patient Information Form, and sign and abide by this Financial Policy. We will also take a copy of your driver's license and current insurance card(s).
- Our fees are representative of the usual and customary charges for our area.
- Charges for minor children will be billed to the parent with whom the child resides. We will bill appropriate insurance if all required information is provided. We will not bill or contact a non-custodial parent on behalf of the custodial parent.
- Dependents age 18 and older will be placed on their own account.
- If you believe your services are covered by another party and supply all required billing information, we will send the claim in for you as a courtesy, however, you remain responsible for payment.

Insurance:

- We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Billing your insurance is a courtesy service we provide for you. In order to do this, we must receive all the information necessary to bill. If the information is not supplied, you will be billed, and payment in full will be your responsibility.
- Your insurance coverage is a contract between you and the insurance company. It is your responsibility to know your insurance benefits.
- We participate in many health insurance plans. If we participate in your health insurance plan, our fees are subject to a contracted fee schedule. It is your responsibility to verify participation prior to service. Participation may change at any time, and changes will be posted at our front desk.
- If your insurance company has not paid within 60 days of service, the payment will become your responsibility. It is your responsibility to contact your insurance company regarding a disputed insurance claim.
- It is your responsibility to notify us of any changes in insurance coverage, and to give us a copy of your current insurance card.

Patient Responsibility for Payment:

- Co-payments, co-insurance and charges that apply to your deductible are due at time of service. Insurance companies require that we collect your copay at time of service. We do not bill for co-pays. If you are unable to pay your copay, we may reschedule your appointment. Three missed copays may result in dismissal from our practice.
- If you pay in full for services not covered by insurance on the date of service, you will receive a 15% discount. This does not apply to co-payments or deductibles required by your insurance company.
- If you are unable to pay and have a good credit history with our office, we may allow you to pay for services on a financial agreement. Reasonable and timely monthly payments are expected. Missing a payment means that you have broken the contract with us and may result in referral to a collection agency and/or dismissal from the practice. We allow one financial agreement at a time per family. The original agreement must be paid in full before another agreement may begin. Additional services will not be added to an existing financial agreement. New patient charges may not be paid on a financial agreement.
- If you are on a payment plan or have had payment issues in the past, we will place your account on "Cash Pay" terms. This means we will require payment of a deposit before you see the doctor.
- We accept payment by cash, check, and certain credit cards. We do not hold checks or accept post-dated checks.

Billing:

- You will receive a monthly statement listing all services, payments and adjustments, and noting the date your insurance was billed. The statement will specify an amount due from you, and payment is due upon receipt.
- A late fee of 18% APR, with a minimum monthly charge of $5, will be added to patient due balances that are outstanding over 30 days.
- If you have no insurance coverage and have difficulty paying for medical care due to limited income, you may apply for our financial hardship policy. Please ask our receptionist for information.

Non-Payment:

- If you do not pay the patient due portion of your bill, our collection analyst will send you a letter stating you must pay within a specified period of time. You must contact her if you want to discuss payment arrangements. Please be aware that failure to pay will result in referral to a collection agency, which may affect your credit rating.
- If we refer your account to a collection agency, you will be charged for all costs and expenses including a $50 collection fee, and any reasonable attorney fees.
- Referral to a collection agency may result in dismissal from our practice.

Services from other Providers:

You may have additional medical services ordered by your doctor, such as laboratory or pathology tests, xrays or other radiology tests. Our clinic may draw your blood, or take a sample, and send it to another provider. You will receive a separate bill from that provider for their services. You must make your own arrangement for payment with providers outside our office.