ARKANGEL ENDOCRINOLOGY AND DIABETES, PLLC

FINANCIAL POLICY

Arkangel Endocrinology and Diabetes, PLLC is committed to the success of your medical treatment and your well being.

Payment of your medical bill is part of your treatment and care.

Our office participates with numerous insurance companies and managed health care

programs. We require you to show your insurance card(s) at every visit.

While we gladly bill your insurance companies for your services, it is important for the patient to be familiar with the guidelines of their insurance plan requirements regarding

authorizations, deductibles, co-payments and other vital requirements.

A copy will be provided to you upon request.

**Co-payment**

The entire amount of co-payment is due on the day of service, or a $10.00 surcharge will be applied.

Our office will submit a claim to your Primary and Secondary insurance as a courtesy,

but you are ultimately responsible for the payment, regardless of your insurance

coverage.

Should you have a third (tertiary) insurance plan, it will be your responsibility

to submit those insurance claims. Please check with your insurance company for

requirements.

**If you are enrolled in an HMO that requires a referral, our office must have a referral**

**prior to your appointment**. If we do not have the referral at your appointment time, your

appointment will be rescheduled for another day.

All charges determined to be your responsibility by your insurance company shall be

paid in full upon receipt of the first statement.

Please notify the Billing Department if assistance is needed to meet your financial obligation. Patient balances past 120 days with no payment or payment arrangements will be turned over to a collection agency.

In the event that we receive a returned check, a fee of $35.00 will be charged to your

account, and payment in full is due upon receipt of your statement.

Arkangel Endocrinology and Diabetes, PLLC strives to offer our patients excellent endocrinology care and assist the patient to receive maximum benefit from their insurance plan.

**Payment Methods**

Payment is expected at the time services are rendered. We accept a variety of payment

methods including cash, check, money order, or credit card (Visa, MasterCard, American

Express, PayPal, and Discover).

There you can set up a recurring payment plan if you desire that option.

**Insurance Information**

We must emphasize that your health is our primary concern, regardless of your insurance.

Because your insurance policy is a contract between you and your insurance company,

please check with your insurance carrier to determine any pre-existing limitation or other

benefit restrictions that you may have PRIOR to your appointment. We will file your

insurance as a courtesy 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. Most

insurance companies do not cover 100% of the cost of services and there is a portion

that is your responsibility.

There are several patient responsibility components that may apply to an insurance

payment:

**Co-pay** – A set dollar amount per office visit that is the patient’s responsibility.

**Co-insurance** – A percentage of the charge that is the patient’s responsibility.

**Deductible** – A set annual amount that the patient is responsible for paying prior to

his or her insurance making a payment.

Because of the contract you have with your insurance company, we are obligated to collect

payment from you for your portion of the balance. All co-payments, co-insurance, and

deductibles must be paid at the time of service.

This arrangement is part of your contract with your insurance company. To bill your insurance accurately and in a timely manner, we will need assistance from you. We ask that you provide our office with accurate demographic information (address, phone number, e-mail etc.) and proof of insurance. All patients will be required to show proof of insurance and a Government issued Photo ID.

**Insurance Changes**

If there are any changes in your insurance, you are required to provide that information to

our office. If you fail to provide us with the correct insurance information in a timely manner,

you may be responsible for the resulting balance.

Managed Care: All Managed Care (i.e. HMO, PPO, POS)

Co-payment, co-insurance, and deductible amounts are due at the time of check-in.

If your insurance plan requires a referral authorization from a primary care physician you are

responsible for obtaining approval from your PCP prior to treatment. If you request an office

visit or procedure without a referral authorization, your insurance plan may deem this as

non-covered treatment and you will be responsible for the charges.

Medicare

We accept assignment with Medicare. Medicare pays 80% of their allowed amount after

satisfaction of the yearly deductible. You are responsible for 20% of Medicare allowed

amount unless you have secondary insurance coverage. All co-payments, co-insurances,

or deductibles are due and payable at the time of service.

Secondary and Tertiary Plans

We will bill your secondary and, if applicable, tertiary insurance as a courtesy. If you have

supplemental insurance to cover the portion of the charges that Medicare or your primary

insurance carrier does not pay, please provide us with a copy of this insurance card.

Prior Authorization

Please remember that it is up to you to understand the requirements of your individual

insurance plan and know whether prior authorization from your insurance company is

required.

Non-covered Services

Any care not paid for by your existing insurance coverage will require payment in full at the

time services are provided or upon notice of insurance claim denial.

Cash Patients

Cash patients are accepted at an already-discounted cash pay rate. All uninsured patients

will be required to pay in full at time of treatment.

**Nonpayment**

Please be aware that patient accounts over 120 days without satisfactory payment

will be turned over to a collection agency and patients will face possible termination from the

practice.

**Returned Checks**

A $35.00 fee will be charged for any returned checks. We will be unable to accept your

checks for any services thereafter.

**Missed Appointments/ Late Arrivals**

In an effort to provide our patients with quality, efficient care, it is necessary for you to

attend appointments as scheduled.

Compliance with your prescribed plan of care is critical for success in your healthcare. If you are unable to keep a scheduled appointment, please cancel or reschedule your appointment at least 24 (twenty-four) business hours in advance to avoid a service charge - **$50.00 for appointments**,

Patients who habitually fail to keep scheduled appointments and do not

give a 24 (twenty-four) hour cancellation notice may face treatment termination. Any patient

later than 20 (twenty) minutes past his or her original appointment time may be asked to

reschedule as that appointment has been missed.

**Medical Records**

Medical records requests will be processed upon receipt of a signed medical release form.

Please be aware that billing records are a part of your medical record and will also require

this form. We can mail it or fax it. In addition, you may retrieve it from the patient portal on

our website.

**Account Billing Questions and Refunds**

Questions or concerns regarding your account or insurance claim should be directed to our

billing office staff. If you feel an error has been made in your statement or if you have any

questions or concerns please contact our office.

Please sign the attached acknowledgement that you have received a copy of our Notice of

Financial Responsibilities, effective immediately. And also, by signing below you agree to any

future phone/recurring payments and/or payment plan set-up to our mutual satisfaction.

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Patient Name Date of Birth

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Responsible Party Name Signature Date