Gary P. Harvey, MD

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FINANCIAL POLICIES

Thank you for choosing our practices for your obstetrics and gynecological needs. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any question about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

Co-pays:

The patient or responsible party is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made. We accept cash, checks or credit cards (master card or visa only).

Insurance Claims:

Insurance is a contract between you and your insurance company. We suggest you contact your insurance company in regards to whether or not we are preferred contracted providers. We will bill your primary, secondary and tertiary insurance companies as a courtesy to you. In order to properly bill your insurance companies, we require that you disclose all insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. If you fail to provide us with insurance coverage for services in a timely manner and your insurance company denies for timely filing, you agree to take full responsibility for those charges. Although we may estimate what your insurance company may pay, ultimately it is the insurance company that makes the final determination of your eligibility and benefits once they receive the insurance claim. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges deemed experimental or investigational, above usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately. To reiterate it is your responsibility as the covered insured on your insurance to know your benefits and exclusions of your policy. We will not fraudulently change diagnoses from the supporting documentation in order for a better outcome from your insurance company. If we have exhausted all our efforts in collecting from your insurance and payment is delayed over 90 days you agree to take responsibility of those charges in arrears up with your insurance company and pay our office in full for such charges.

Specialty and Surgical Services:

We do supply some services that we are aware of that insurance carriers do not consider a covered benefit of contracts such as infertility testing, ultrasounds done to determine sex of baby, and with some policies contraceptiondevices and placement verification ultrasounds (IUD and Nexplanon)and lastly some surgical procedures. For any noncovered services our office will require payment in full on the day of services. If you are scheduled for a surgical procedure and/or IUD/Nexplanon insertion, we will expect your copayment, coinsurance, and/or deductible prior to the services provided. The physicians order labs and pap smear testing, ultrasounds and perform deliveries and surgical procedures outside our office at other facilities (Community Medical Center and/or Big Sky Surgery Center). We strongly suggest you contact the facility and your insurance company prior to services and find out whetherthe facility is a preferred contracted provider, responsibilities such as costs, insurance coverage, in-network or out of network, pre-authorizations and referrals are required.

Referrals and Pre-authorizations:

If your insurance company requires a referral and/or pre-authorization, you are responsible for obtaining it. Failure to obtain the referral and/or pre-authorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility.

Self-Pay Accounts:

Self pay accounts are patients without insurance coverage or month to month insurance plans, patients covered by insurance plans in which the office does not participate, and/or patients without an insurance card on file with us. If there is a discrepancy with the information you have provided to us, the patient will be considered self-pay unless otherwise proven. Self-pay patients will be required to pay in full at time of service.

Missed Appointments:

There will be a $50 fee for missed appointments if you do not give a 24-hour notice. This charge cannot be billed to your insurance; therefore, it will be solely your responsibility. After three consecutive missed appointments, you may be dismissed from our practices.

Returned Checks:

The charge for a returned check is $30 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check. Payment on non-sufficient funds checks are expected immediately upon notice from financial institution.

Medical Record Copies:
All requests for medical records must be done so in writing, please allow us 10 working days to complete the request this is within the legal limits. Please be advised that there is an administrative fee of $15 and a fee of $0.50 per page and this is assessed at the discretion of our office and is in accordance with Montana Annotated code.

Prescription Refill Requests:
It is our office policy to refill medications during office hours only. We are required to keep accurate records of all medications prescribed to stay within state and federal laws and prescribing guidelines. Therefore, you may be required to have an exam yearly. When you notice, you have only three days remaining, please call your pharmacy. If you need another refill the pharmacist will contact us via e-scribe, phone, or faxed request. E-scribe requests are the preferred method for refill requests and create less chance of errors of the wrong drug or dosage being refilled. Allow 72 hours (3 working days) for our office to refill your prescription(s) in a timely manner.

Minors:
The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. Minors must be accompanied by a parent or guardian unless a signed release to treat and financial arrangements have been made prior to services.

Outstanding Balance Policy:
It is our office policy that all accounts are paid within 90 days. All past due accounts will be sent a 60 day collection letters. If payment is not received within the 90 days, the account will be sent to the collection agency that we work with, I understand that I am personally responsible to pay all collections fees associated with my account, including a reasonable attorney fees and reasonable agency fees. I understand that in the event my account is turned over to a third party collection agency, a collection fee is the amount of up to 50% of my account balance will be added to my balance and that I am responsible to pay that amount. Once your account is turned over to the collection agency you will be considered discharged from the practice until financial obligations have been met and satisfied. If financial obligations are met you will be welcomed back into our practice but as a cash at time of service patient until a sufficient period of time.

Refunds:
If you feel you have a refund coming it is your responsibility to contact our office and request such refund. Refunds will only be issued after all dates of service have been paid in full by you or your insurance. If it is deemed, you have a refund coming an audit will be done on your account and a refund check will be issued. Please note refund checks are only issued once a month. If a refund is due to you and payment was made via credit card (master card or visa), please be advised that a 2% to 5% fee will be deducted from your refund due to credit card fees. Patient using a care credit card, please be advised that a 15% fee will be deducted from your refund due to care credit fees.

Cell Phones:
By providing a cell phone number you have authorized contact for any activity involving our services to you, including but not limited to the resolution to the balance of your account. This number will only be used for in-house or any business entity contracted to perform duties resulting from services provided to you by this office.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving services, you are ultimately responsible for payments on your balance. Our office will not bill any other personal party.

Authorization to Release Information and Assignment of Medical Benefits:
I hereby authorize Gary P. Harvey MD to treat the below-named patient. I authorize the release of medical information necessary to process insurance claims for treatment. Photocopies and electronic signed versions of this form are valid as the original. I authorize medical benefits to be directly paid to Gary P. Harvey MD. I understand that I am financially responsible for any services from this office regardless of insurance coverage.