



## **PATIENT RESPONSIBILITY AND FINANCIAL POLICY**

Thank you for choosing The Center for Internal & Integrative Medicine as your healthcare provider. The following is a statement of our Financial Policy and patient responsibility relating to payment for services, which you are required to read and sign, prior to treatment. Please understand that timely payment of your bill is considered part of your care.

Due to frequent changes in health insurance coverage, we require that you provide proof of insurance coverage at every visit. If you are unable to provide proof of insurance, have a plan that we do not accept, or do not have insurance coverage, full payment is required at the time of your visit. If we are a participating provider, we will routinely file a claim for services rendered, although **all co-pays, co-insurance, and deductible amounts are due at the time of service**. If a patient has a plan we do not accept, **full payment is due at the time of the service**; however, we will provide you with a copy of your invoice at each visit, so you can file your claim with your insurance company.

### **Various Health Insurance Coverage and Reimbursement Plans**

The patient understands that insurance companies have different requirements for payment and reimbursement, including, but not limited to, pre-certifications, referrals, authorizations, or medical necessity for treatment. It is the patient's obligation to know the Insurance Company's requirements and ensure that those requirements are fulfilled, prior to receiving treatment. It is the patient's responsibility to obtain any referral or prior authorization that the Insurance Company requires.

Should there be a dispute with your insurance company, we will attempt to resolve it for you. During this time, you will receive a monthly statement that your account shows an outstanding balance for all services. If your insurance company has not paid within ninety (90) days of the treatment date, you will be personally responsible for full payment of that balance. **Your insurance policy is a contract between you and your insurance company. Even though you have health insurance, you are responsible for payment of all services provided by The Center for Internal & Integrative Medicine.** It is your responsibility to immediately update The Center for Internal & Integrative Medicine of any insurance changes, so the correct insurance company is billed for services rendered. Please list The Center for Internal & Integrative Medicine as your Primary Care Provider (PCP) with your insurance company.

### **Insured Individuals Electing Self-Pay**

The patient reserves the right not to file a claim with their health insurance company, and, instead, elect to pay out of pocket for services provided. In that event, the patient is financially responsible for all charges incurred, and payment is due at the time of service. **After the services have been rendered, the patient will not be able to file a claim with their health insurance company due to insurance claim submission requirements. The Center for Internal & Integrative Medicine will not submit any claim to a health insurance company for services where the patient elected to self-pay.** The patient's election to self-pay for certain services does not affect or reduce any out of pocket financial responsibility for future services; the out of pocket costs are defined in the health insurance coverage plan.

### **Interest, Late Fees, and Collection Costs**

We reserve the right to charge interest in the amount of 1.5% monthly (18% annually) on all past due account balances, as provided by state law. A late fee of \$20.00 is applied to any item unpaid after insurance has adjudicated the claim (or 60 days from the date of service, whichever is first). Any delinquent account referred to collections will have a \$30.00 collections charge applied. In addition, you are responsible for all legal fees, attorney's fees, collection costs, and any miscellaneous expenses related to the collection of delinquent accounts.

**401 S. Main Street, Unit B-3• Alpharetta, Georgia 30009• (404)836-9906**

Initial: \_\_\_\_\_



### **Missed Appointments**

If a patient is unable to make a scheduled appointment, at least a 24-hour notice is required because missed appointments are very disruptive to the operation of our office. Furthermore, other patients are deprived from potential appointments. **If a patient misses a scheduled appointment without the minimum 24-hour notice, the patient will be charged a \$75.00 fee. This fee is solely the patient's responsibility and cannot be billed to the health insurance provider.** If you repeatedly miss scheduled appointments, you may be asked to seek medical care elsewhere. For more information regarding missed appointments, please review our Policy for Rescheduled and No Show Appointments.

### **Returned Check Fees**

Anytime a check is returned for insufficient funds; there is a stopped payment on an issued check; or the check is drawn on a closed account, the Patient will incur a \$30.00 processing fee. That fee is applied to your personal account balance and must be paid within fourteen (14) days of notification. If a patient has more than two (2) checks returned for insufficient funds, we will require payment in cash or approved credit card for all visits thereafter.

### **Delinquent Accounts**

If a large bill is anticipated and financial arrangements need to be made, a payment program may be arranged with our Practice Administrator, prior to your visit. Failure to resolve any past due accounts, including any returned checks, will result in referral to a collection agency. Any patient, whose account is forwarded to a collection agency, will be dismissed from our practice. If you are on a plan that requires you to be assigned to a Primary Care Physician (PCP) then a copy of the dismissal letter will be sent to the insurance company so they can reassign you to another PCP.

### **Transferring of Medical Records**

Because there are frequent changes in health insurance coverage and participating providers, it is often necessary for patients to ask that their medical records be transferred to another physician's office. An immunization record and problem list can be provided at no charge. Otherwise, there will be a \$25.00 administration fee for records that are transferred.

### **Nurse Fee**

Any procedures performed by the lab nurse (strep screens, lab work, hearing and vision, etc.), that do not require a face-to-face visit with the physician, will incur a nurse fee in addition to the fee for the procedure performed. All appropriate co-pays will apply.

All patients are asked to please check out before leaving the office. It is unlawful to intentionally leave without satisfying your financial obligations after treatment has been rendered. Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have carefully reviewed and understand this Patient Responsibility and Financial Policy.

Signature of Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_