Financial Policy – March Ob/Gyn

OUR PROFESSIONAL SERVICES ARE RENDERED TO YOU, THE PATIENT, NOT TO THE INSURANCE COMPANY. THEREFORE, PAYMENT FOR CARE IS YOUR RESPONSIBILITY.

This is an agreement between Michael R. March, M.D., P.A. and you, the patient. Feel free to ask any questions regarding these financial policies. By signing this agreement, you agree to all the policies stated below. **Write your initials in each space marked "*_____".**

***_____ Insurance Filing and the Law**

You, the patient, authorize this office to directly bill your insurance company, and to release/receive any information necessary to perform insurance claims. If the insurance company fails to pay your balance in full, or there is no insurance payment made within 45 days, IT IS YOUR RESPONSIBILITY TO PAY DOCTOR'S BILL DIRECTLY, to the extent consistent with any payor contractual agreement. Such payment is not contingent on any settlement or judgment. You authorize insurance payments be made directly to Michael R. March, M.D., P.A. In the event payment is sent to the patient, the patient agrees to endorse any payment received to Michael R. March, M.D., P.A. for which this fee is payable. Recent federal laws addressing all insurance companies require that we submit your claim to the insurance company accurately, reporting the exact services performed and the exact reason for performing them. We do not alter this information just so the claim can be paid by the insurance company. **All "out-of-pocket" charges, including deductibles, co-pays, co-insurance, and other similar charges, <u>are due at the time service is rendered</u>.**

***_____ Non-payment of Co-pay**

Your insurance requires us to collect your co-pay when services are rendered. You give us permission to notify your insurance company if you fail to pay your co-pay, and other "out – of-pocket charges, such as deductibles and/or co-insurance.

***_____ Broken Appointments**

It places undue hardship on our other patients when appointments are broken. You are required to give a <u>24-hour notice</u> if you cancel or reschedule an appointment. If you do not provide notice more than 24 hours prior to an appointment, and subsequently fail to arrive in our office at the scheduled appointment time, you will be charged a fee (currently $80). =Arriving late, after the time of your scheduled appointment, also constitutes a broken appointment, and you may be asked to reschedule for another day and time.

***_____ After Hour Prescription Refills**

We ask that prescription refills be made during regular office hours. There is a fee (currently $30) for prescription refills made after office hours. You will ultimately be responsible for this charge.

***_____ Payment at the time service is rendered**

If we participate with your insurance company, we require you to pay your co-pay, co-insurance and deductible amounts at the time of your visit. We accept payment by cash, check drawn on a local bank, Visa, MasterCard or Money Order. We will file your insurance to extent our capacity allows. If we do not participate with your insurance company, or you do not provide us with proof of insurance, we will require you to pay in full at the time of your visit.

***_____ Past Due Accounts**

If your account becomes past due, we will take necessary steps to collect this debt. If we refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. If we refer collection of a balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs.

You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as The Credit Bureau.

You understand if this account is submitted to an attorney or collection agency, if we litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

***_____Completion of Forms**

There is a fee (currently $15) for completion of forms and/or production of letters during a patient's care. This fee does not pertain to forms used to submit charges for services rendered. This fee is due from you prior to the release of the form/letter. We require at least 3 business days to complete forms and ask you to pick them up at our office when completed.

These forms include, but are not limited to:

- Disability Forms
- Leave of Absence Forms
- Letters to Employers
- Letters regarding the coverage of birth control pills used for reasons other than birth control
- Letters regarding flying and/or airline tickets
- Letters or forms regarding exercise classes, fitness clubs, or similar activities.
- FMLA forms
- Merck Medco Rx. Forms

***_____Commercial Labs (Quest, LabCorp, Spectrum, Rex, etc.)**

You will need to contact the lab service if you have any questions about your bill or insurance payment, or denial, in reference to lab services provided by the lab.

***_____ Prescriptions for UTI and/or vaginitis**

If your think that you may have a urinary tract infection (bladder infection) and/or vaginitis, you need to see a physician so that a urinalysis and/or wet mount can be performed. If you decline to schedule an appointment, and the physician elects to treat you without seeing you in the office, there is a fee (currently $30) for taking your call, providing physician consultation by phone, and calling in a prescription. This applies to such consults that occur during or after regular office hours.

Some insurance companies may not pay for consultation for urinary tract infections (UTI) if seen at a gynecologic practice, but will pay at a primary care practice. Therefore, you should check with your insurance company prior to calling for UTI consultation.

***_____ Returned Checks**

There is a returned check fee (currently $25) for checks returned to us not paid.

***_____ Worker's Compensation**

We require written approval/authorization by your employer and/or worker's compensation carrier prior to your visit. If your claim is denied, you will be responsible for payment in full, to the extent allowed by law or policy.

I HAVE READ AND UNDERSTAND BOTH PAGES OF THIS POLICY:

Patient's Name - Printed _____

Signature of Patient _____ Today's Date _____

_____ _____

Legal Guardian (if applicable, or if under 18 years old) Signature of Legal Guardian