UNIFOUR FAMILY PRACTICE

PRINT

STATEMENT OF FINANCIAL AND GUIDELINE POLICY FOR OUR PATIENTS

We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this financial and guideline policy. Please read it, ask us any questions you may have and sign the space provided. A copy will be provided to you upon request.

1. **INSURANCE:** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but **do not have an up-to-date insurance card, payment in full** for each visit will be required until we can verify your insurance coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

   Insurance cards/Coverage Changes:

   If your insurance changes, you are required to notify us before or at your next visit so we can make the appropriate changes to help you receive your maximum benefits. Please bring insurance card to all appointments.

2. **Co-payment, Co-insurance and Deductible:**

   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. We accept cash, check or credit card (Visa, Master Card and Discover and American Express).

3. **Non-Covered Services:**

   Please be aware that some-and perhaps all-of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. Payment will be required in full for these services at the time of the visit. You will be required to sign an advanced beneficiary notice (ABN) to acknowledge that you are aware that your insurance may not cover these services and that you are financially responsible for payment of this service.

4. **Medicaid:**

   We accept Medicaid for children who are **12 years of age and under**. You must provide proof of coverage by presenting your Medicaid card each time you visit our office. If you are enrolled in Carolina Access, our name must appear on your card. It is your responsibility to ensure that our name is listed as your primary care physician on your card. If you have a co-pay with your Medicaid, you are required to pay this co-pay at the time of service.

5. **Claim Submission:**

   We will submit your claims 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. Your insurance benefit is a contract between you and your insurance company we are not party to that contract.

6. Nonpayment:

If your account is over 60 days due, you will receive a letter stating that you need to pay your account in full within 10 days. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to an outside collection agency and you and your immediate family members may be **discharged** from the practice. If this occurs, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Effective immediately - if in the past, a balance on your account was transferred to an outside collection agency, you will be required to pay in full at the time of service all co-pays, co-insurance, deductibles, and non-covered services for that date of service. You will also be required to pay your collection balance in full.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our geographic area.

7. Missed Appointments:

Our policy is to charge a **fee of $28 for missed appointments** not cancelled within 24 hours preceding the date of your appointment. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointments. If you no show 3 times for an appointment, you may be terminated from the practice.

8. Late Appointments:

If a patient is late for an appointment, you will be given the option to reschedule or wait to be seen for an acute (sick) visit only. Please be advised that if you select to wait to be seen for an acute illness, you will be worked in the schedule and patients with scheduled appointments will be seen prior to you. You will be considered late for a scheduled appointment if you arrive **15 minutes after** the time of the appointment. We know that traffic is impossible to predict, so **please** allow extra driving time.

9. HIPAA PRIVACY STATEMENT:

HIPAA Privacy Statement is required to be completed by all new patients and **updated on a yearly basis** by all patients in order to disseminate information and records concerning your medical health care and services that you receive at this office. This form describes the way we may use and disclose protected health information about you and also describes your rights and obligations regarding the use and disclosure of that information.

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Acknowledgement/agreement to our guideline policy.

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Patient/Guardian Signature Date