MAXA INTERNAL MEDICINE ASSOCIATES, P.C.
PRACTICE FINANCIAL POLICY

If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and understanding of our financial policy. If you do not currently have coverage or cannot provide our office with an active insurance card we will collect payment at the time of service. .

CO-PAYMENTS / CO-INSURANCE / DEDUCTIBLES: These payments must be made either at time of service or at check-in. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, co-insurances and deductibles from patients is considered a violation of our contract. Please help us uphold the law by making your co-payments and co-insurance at each visit and paying deductibles owed at the beginning of the year (including Medicare deductibles and 20% co-insurance). We will estimate what you payment will be, apply it to your account and file your insurance. Any difference in payment will be invoiced to you after the Explanation of Benefits is received by us from your insurance company. If you are unable to pay your co-payment, co-insurance or deductible at the time of service then you may be asked to reschedule your appointment or pay a fee of $25.00 for non-payment at the time of service.

CLAIM SUBMISSION: As a courtesy to you, we will process and file your insurance claims for services rendered by our Practice. Your insurance company may need additional information from you to process a claim, and it is your responsibility to comply with their request. **If your insurance company has not paid your claim within 60 days, the balance becomes your responsibility.** Your insurance is a contract between you, your employer and/or the insurance company. While we may provide services, we are not a party to that contract. We encourage you to contact your insurance carrier personally in order to remain informed of your benefits. Please note that we cannot hold claims waiting on your insurance information as the insurance company has a timely filing deadline. If you don't have the appropriate information at the time of service then payment in full will be collected.

NON-COVERED SERVICES: Not all services are covered by insurance; they vary from contract to contract. Some insurance companies arbitrarily select certain services they will not cover or which they may consider not medically necessary. In these instances, you will be responsible for these services. We will make every effort to ascertain your coverage for our services **before** treatment and make you aware of our findings. However, this does not guarantee payment from your insurance carrier. For in-house diagnostic testing we will attempt to get an amount from your service company however if you are concerned about the amount of cost that will be put to patient balance, please call your insurance company with the CPT codes to confirm this amount. Please note that when we request the amount of patient balance the insurance company gives a disclaimer that this is an estimate and that they won't know the balance until the actual claim is filed.

For services that are not covered by insurance, the Practice requires payment of 100% of the total charges at time of service unless prior arrangements have been made.

COVERAGE CHANGES: If your insurance changes, please notify us as soon as possible so that we can update our records and help you receive the maximum benefits allowed under your coverage. If you are insured by a plan that we accept, but you do not have a current insurance card, payment is expected in full at time of service until we can verify your coverage.

MISSED APPOINTMENTS: We require 24 hour notice for appointment cancellations. Please be aware that there is a $75.00 fee for missing a scheduled physical or new patient appointment. The fee for a missed regular appointment is $25.00. Due to the fact that we have an outside company performing certain Ultrasounds tests in the office, there is a missed appointment fee of $75 for these specialty tests. These charges are your responsibility and are not billed to your insurance company. Please help us in serving you better by keeping your scheduled appointments or by giving 24 hour notice before any cancellation.

NONPAYMENT: Balances are due upon receipt of our invoice. If your account is over 60 days past due, a late fee of $25.00 will be added and interest at the rate of 16% per annum, or 1.33% per month will accrue monthly. Our Billing department will work with you on monthly payment arrangements as long as you have a credit card to leave on file for the monthly amount of your payment. Please be aware that accounts that are 60 days past due are subject to being sent to a collection agency by our management company unless you have made arrangements for a payment plan with our office. Your account will become inactive until paid**.** If your account is turned over to an attorney or pursued legally for collection, you will be responsible for all reasonable attorney's fees, filing fees, and service fees.

RETURNED CHECK FEE

If a check is returned there will be a $30.00 returned check fee. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in managing your account. Our Practice is committed to providing quality medical care. Our prices are representative of the usual and customary charges for our area.

PRIOR AUTHORIZATIONS FOR NON-COVERED MEDICATIONS

Our office will process up to 2 Insurance Prior-Authorizations per patient for medications at no charge to the patient annually. After 2 P.A's have been processed there will be an administrative charge of $25.00 per P.A. If you wish to minimize your costs then please speak to your insurance company about which medications they prefer.

FORM FEES

There is a fee for form completion of $25.00 - $35.00 depending on the length of the form. This must be paid at the time that the form is sent in. Please note that some forms also require an office visit to be completed.

Thank you for understanding our financial policies. Please let us know if you have any questions or concerns about the above information or any uncertainty regarding your insurance coverage. ***We are here to help!***

PLEASE READ THE ABOVE FINANCIAL POLICY CAREFULLY BEFORE SIGNING.

I hereby authorize photocopies of this form to be as valid as the original.

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____