HALLSVILLE
— MEDICAL CLINIC —

Patient Financial Policy

Thank you for choosing *Hallsville Medical Clinic* for your healthcare needs. We want to provide you with quality healthcare and a clear understanding of our Patient Financial Policy is vital to that relationship. Please ask if you have questions regarding our fees, policies, or your responsibilities.

_____**INSURANCE** – We participate in some but not all insurance plans. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

- If you are insured by a plan, we are credentialed with but don't have an up-to-date insurance card, or the benefits can't be verified, payment in full for the visit is required.
- If you are not insured by a plan, we are credentialed with payment in full is required at each visit, or you may request to be seen as a self-pay patient to have access to our reduced fee schedule. A claim will not be generated or filed in this situation.

_____**COPAYMENTS AND DEDUCTIBLES** – All copayments and deductibles must be paid at the time of service. This arrangement is part of the contract with your insurance company.

- Failure for our office to collect, or for the patient to pay copayments/deductibles can be considered fraud.
- To make payments convenient we accept VISA, MasterCard, American Express, Discover, Care Credit, Cash, local checks.
- Please complete the Credit Card Authorization form attached.

_____**NON-COVERED SERVICES** – Please be aware that some or all of the services you receive may not be covered by your insurance plan. You will be required to pay for these services in full.

_____**PROOF OF INSURANCE** – All patients must complete all patient information forms before receiving healthcare services.

- We will need to obtain a copy of your driver's license and current valid insurance to provide proof of coverage.
- If you fail to provide us with the correct insurance information/identification, or order of coverage in the case of multiple policies, in a timely manner you will be responsible for the unpaid portion of the claim filed. Be sure to coordinate benefits with your insurance carriers so that you know which plan is primary and which is secondary.

_____**CLAIM SUBMISSIONS** – We will submit 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 requests.

- The balance of your claim is your responsibility regardless of if your insurance company pays the claim.

_____**COVERAGE CHANGES** – If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive maximum benefits. It is the policy holder's responsibility to provide our office with correct and current information for filing claims.

- If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

_____ **NON-PAYMENT** – It is our office policy that all past due accounts be sent 2 statements. If payment is not made on the account a single phone call will be made to collect the debt.

- If no resolution can be made the account will be sent for collection and could result in being discharged from the practice.

_____ **MINORS** – (less than 18 years of age)

- The parent or guardian is responsible for full payment and will receive a call from the office to make a payment over the phone if the minor presents without payment for the services.
- A signed release to treat a minor in the absence of the parent/guardian is required.

_____**SELF PAY ACCOUNTS** – Self pay accounts are for patient's without insurance coverage, patients with insurance plans in which the office does not participate, or patients without an insurance card on file.

- If a patient presents a self-pay status it is understood that an insurance claim will not be submitted to an insurance company.

Patient/Guarantor Signature _____ **Date** _____

Witness _____ **Date** _____

My initials and signature are evidence that I have read, understand, and agree with the financial policy of the Hallsville Medical Clinic.

CREDIT CARD AUTHORIZATION FORM

Credit Card Information

MasterCard VISA Discover AMEX CareCredit OTHER:

Card Number:

Expiration Date (mm/yy): **CVC :**

Cardholder ZIP Code (from credit card billing address):

I, _____ , authorize *Hallsville Medical Clinic* to charge the credit card above for the balance owed for the purchase of medical services. I understand that my information will be saved to file for future transactions on my account.

Customer Signature: **Date:**

Witness Signature: **Date:**

By signing this form, you, the patient or responsible party, give permission to Hallsville Medical Clinic to process payment for services provided and fees associated with the collection process. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until it is cancelled.