



3537 West Front Street, Suite E Traverse City, MI 49684
Phone (231) 935-8930 Fax (231) 935-8811

FINANCIAL POLICY

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. This policy will answer your questions regarding your financial obligations. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **INSURANCE:** We participate with several insurance plans. If you are not insured by a plan that we participate with, payment in full is expected at each visit. If you are insured by a plan we participate with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company prior to your visit for coverage information.

2. **PROOF OF INSURANCE:** It is your responsibility to provide us with your current address and insurance information. Please let us know immediately if these have changed. We must obtain a copy of your current valid insurance card. If you fail to provide us with the correct insurance information, and the insurance we bill denies your claim, you will be responsible for the balance.

3. **CO-PAYMENTS AND DEDUCTIBLES:** All co-payments and deductibles must be **PAID AT THE TIME OF SERVICE**. This arrangement is part of your contract with your insurance company. If we are unable to collect your co-payment on the date of service, a fee will be added to your visit. If your current co-payment cannot be determined, you will be expected to pay a preset amount.

4. **NON-COVERED SERVICES:** Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by your insurance company. The provider's decision to order tests, x-rays, labs, and any other medical services is based on your health care needs, not your insurance coverage. It is your responsibility to know your insurance coverage before any services are rendered.

5. **CASH DISCOUNT:** We offer a percentage cash discount for the uninsured or for non-covered charges for the insured. Your charges must be paid in full on date of service in order to receive this discount. Once you receive a cash discount, we will not bill your insurance for the charges for any reason.

6. **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. If your insurance does not pay your claim within 45 days, that balance will automatically be billed to you.

7. **PAYMENTS:** We accept cash, check, money order, Visa, MasterCard and Discover. Our billing office is staffed Monday – Friday from 8:00am – 4:30pm. Our phone number is (231) 935-8983. For your convenience, we are able to accept credit card payments over the phone. We do not accept insurance checks made payable to the patient or subscriber.

8. **NON-PAYMENT:** If your account is 90 days past due, a service fee will be added to your account. You will receive a letter stating that you have 14 days to pay your account in full. Partial payments will not be accepted, unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this occurs, you will be notified by mail that you have 30 days to find alternative medical care. During that 30 day period, our provider will only be able to treat you on an emergency basis.

9. **EXTENDED CARE HOURS AND FEES:** If you are seen Monday-Friday 5pm or later or on Saturday, there will be an additional fee added to your visit. Your insurance may or may not pay this fee. If the fee is not paid or applied to a deductible or co-payment, you will be responsible for the balance.

10. **MISSED APPOINTMENTS:** Our policy is to charge a fee for missed appointments not cancelled within 24 hours before the appointment time. This fee will be your responsibility and billed directly to you. Three non-cancelled missed appointments may be grounds for discharge from our practice. Please help us to serve you better by keeping your scheduled appointments.

11. **AUTO ACCIDENTS:** Please advise our staff and provider that the visit may be auto related. You will be given a form to fill out. We will need a claim number, date and time of accident, and billing address of auto carrier. You will need to know if your health insurance should be billed primary to your auto insurance.

12. **WORKER'S COMPENSATION:** Please advise our staff and provider if there is any reason your visit may be work related. You will be given a form to take to your employer to be filled out and faxed back to us. Until we receive the form back, the charges will be your responsibility. We will not bill your health insurance if there is any reason to believe this visit is work related.

Your care is a partnership between yourself and your provider. Our practice is committed to providing the best treatment to our patients. In return, we ask that you provide us with your most current address and insurance information and make timely payments. Thank you for understanding our payment policy. Please let us know if you have any questions.