



RAU FAMILY MEDICINE

Financial Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable care. In order to answer some of our patients frequently asked questions regarding patient and insurance responsibility for services rendered we have developed this payment policy. 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.

Insurance: Please be aware that insurance is considered a method of reimbursing the member for fees paid to the doctor and is not a substitute for payment. Payment for the account remains your responsibility. We participate in several insurance plans, including Medicare. If you are not insured by a plan we are contracted with payment in full is expected at each visit. If you are insured by a plan we are contracted with, but don't have a current insurance card, you will be considered a self pay patient until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. Self pay patients will be required to deposit \$60 prior to seeing the physician. Your balance will be reconciled after you have seen the doctor. There is a 25% discount for same day payments.

Co-payments and deductibles: All co-payments and deductibles must be paid at the time of service. Your account may be assessed a \$25 charge for not making your co-payment. This requirement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding our contracted agreement with your insurance company by paying your co-payment at each visit.

Non-covered services: Please be aware that some of the services you receive or may wish to receive may be non-covered or considered unreasonable or medically unnecessary by Medicare or other insurers. Payment for these services in full will be required at the time received.

Proof of Insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims 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 the request.

Coverage changes: If your insurance changes, please notify us immediately so we can make the appropriate changes to help you receive your maximum benefits. Failure to notify us of this information within 30 days will result in the balance becoming the responsibility of the patient.

Nonpayment: If your account is over 90 days past due, you will receive a letter stating that you have 10 days to pay your account in full or set up a payment plan and schedule that resolves your debt responsibility in a timely manner. Partial payments will not be suffice unless otherwise negotiated. Should you default on payment your account may be referred to an outside agency for collection. Should this become necessary you will be responsible for all collection fees and court costs associated with the collection of the debt and you will be discharged from the practice.

Missed appointments. Our policy is to charge for missed appointments not cancelled within 24 hours of the appointment. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment. We utilize an automatic calling system that will contact you 48 hours in advance of your appointment.

Our practice is committed to providing the best treatment to our patients.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

Signature of patient or responsible party

Date