



FINANCIAL POLICY

EFFECTIVE 11/1/2006

Thank you for choosing Internal Medicine Associates of Charlotte, PA. Our office is committed to assisting you with timely insurance filing and payment of your account. Please read and sign our financial policy below.

Insurance

Our office participates with most insurance companies. For your protection, we will require your current/valid insurance card along with your photo identification. This information will be kept in our records and assist us in filing your insurance claim. Please remember, it is your responsibility to keep us informed of any changes in your health care coverage, address and telephone contact numbers.

At the time of your visit, we will verify your insurance benefits. The information obtained is not a guarantee of payment and final eligibility/benefits are not determined until the claim is received and processed by your insurance company. If we are unable to verify coverage and/or eligibility, you will be required to make pre-payment. The pre-payment amount is \$90.00 if you are an established patient or \$130.00 if you are a new patient. At the end of your visit, the physician will indicate what services were rendered and the balance of your visit is due prior to leaving. For your convenience, we accept cash, checks, debit cards, Visa, MasterCard, and Discover. (Please note, the cardholder must be the patient.)

After filing your claim, we will allow sixty days for your insurance company to make payment. If your insurance company fails to render payment, you will be responsible for payment in full.

Co-payments/Deductibles/Co-Insurance

Please have your co-payment/co-insurance/deductible at the time of your appointment. These amounts are determined by your insurance company depending on your plan.

Self Pay (No Insurance)

If you do not have insurance, payment in full is expected at the time services are rendered. Upon checking in at the front desk, a prepayment amount of \$90.00 if you are an established patient or \$130.00 if you are a new patient is required. At the end of your visit, the physician will indicate what services were rendered and the balance of your visit is due prior to leaving.

Physical Examinations/Testing/Procedures

If you are scheduled for a routine Physical Exam, lab testing, diagnostic test or diagnostic procedures please check with your insurance carrier to verify if this is part of your covered benefits. If we are unable to verify coverage for these services, you will be asked to pay this at the time of your visit. If your insurance carrier denies payment, you will become financially responsible for these charges,

Missed Appointment Fees

If you cannot keep your appointment, you must cancel 24 hours prior to your scheduled appointment. As a courtesy to our patients, we will attempt to contact you the day before your scheduled appointment is to take place. However, it is ultimately your responsibility to keep track of your appointments. A \$50.00 fee is charged for each missed appointment and a fee of \$75.00 is charged for missed Physical Examination appointments. If you miss two or more appointments, you may be dismissed from the practice.

Worker's Compensation/Automobile Accidents

We are unable to treat any patient that is seeking treatment related to an accident, injury and/or illness involving but not limited to: Worker's Compensation, Automobile Accidents or any other circumstance that may have present or future litigation.

Patient Account Balances

You may have a balance remaining on your account after your insurance company has processed your claim. Our office mails patient statements on or near the first of every month for any balances due on patient accounts to the address we have for you or the guarantor on file. A patient who owes a balance on their account must be prepared to pay the balance in full upon their arrival of their next scheduled appointment. Failure to do so may result in cancellation of the scheduled appointment. If you are unable to pay the balance in full, you will need to contact our office in order to discuss this matter. A late penalty of 1.5% monthly (18% annually) is added to unpaid personal balances after sixty days. All accounts with balances over ninety days will be referred to our collection agency.

BY SIGNING BELOW, YOU ACCEPT AND CONFIRM THAT YOU HAVE READ AND FULLY UNDERSTAND OUR FINANCIAL POLICY.

X _____
Patient Signature

Date _____