OLYMPUS FAMILY MEDICINE

Initial All Below **PAYMENT POLICY**

x_____ **Co-payments, Co-insurance and Deductibles:** **ALL** co-payments, co-insurance and deductibles MUST be paid at time of service. The amount paid when services are rendered is an estimated amount based on the information we receive from your insurance company. Final determination of charges will be made after your insurance has been filed. We will send you a statement for any remaining balance. For your convenience, we accept MasterCard, Visa, Discover, and American Express. **Procedures-** most insurance companies require patients to pay a separate Surgical Deductible for procedures such as cryo-surgery, biopsies, device insertion, and other surgical procedures. Check with your insurance BEFORE the procedure is performed. You are responsible for payment of the deductible at the time of service.

x_____ ***Note to Medicare Patients****:* Medicare has a 20% co-payment for office visits and a yearly deductible that must be paid at the time of service. Some secondary insurance may cover these expenses. Some of the services you receive may not be covered or may be deemed not medically necessary by Medicare or other insurance companies. We require an **Advanced Beneficiary Notice** (ABN) to be signed if there is a possibility that Medicare may deny service. You have the right to decline the service. You will be responsible for payment of all charges for services not covered by Medicare or your secondary insurance company.

x_____ **Insurance:** All patients must provide a valid Driver's License and an **active** insurance card at the time of service. If you fail to provide us with correct insurance information, you will be required to pay the full amount of the service.

x_____ ***You are responsible for knowing your insurance policy and benefits.*** Your health insurance policy is a contract between you and your insurance company. As a courtesy, we file your claim with your insurer if you agree to have payments made directly to *Olympus Family Medicine*. If your insurance company does not provide payment within **90** days of the filing date, YOU will be required to pay the full amount. If we later receive a check from your insurer, we will issue you a refund.

x_____ ***You are responsible for payment of all charges for services NOT covered by your insurance company.*** We do our best to determine your insurance benefits and coverage; however, due to the constant changes in insurance coverage, we cannot guarantee that Medicare or other insurance companies/policies will cover the services rendered. Your insurance company will make the final determination upon receipt of the claim.

x_____ **Appointment Cancellations:** Please provide a minimum of **24 hour** notice when cancelling an appointment. Late cancellations and missed appointments will be charged a **$50.00** fee.

x_____ **Billing:** Our billing is out-sourced to W*allace Medical Billing.* Any balances owed to *Olympus Family Medicine* are due upon receipt of the billing statement. Please call *Wallace Medical Billing* at 1-800-274-7068 for all billing inquiries. All billing questions concerning laboratory or radiology must be directed to the facility where services were performed (*LabCorp, Quest, etc*.).

x_____ **Delinquent Accounts:** If your account becomes delinquent after 30 days, you will be assessed a $5.00 fee per billing cycle, every 30 days. If payment is not made, your account will be turned over to a collection agency due to delinquency and you will be required to pay all balances in full **before** further services are rendered.

By signing this form I acknowledge that I understand and agree to the above payment policy. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my insurance claim. This authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this form I am responsible for payment of services in full before services are rendered.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy.

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Signature of Patient, Parent or Legal Guardian Date

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Print Name of Patient

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