Premier Women's Care
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2017 OFFICE FINANCIAL POLICY

Premier Women's Care believes all patients deserve the best medical care that can be provided. In order to provide the highest quality medical care, we must ensure we are able to meet the expenses necessary to operate this office. To ensure these expenses are met, we provide you with this agreement to acquaint you with our financial policy. We hope that by providing you with our policies in advance, we can prevent any misunderstanding or frustration at the time of your visit.

Initial_____ **Insurance:** When making your appointment, it is your responsibility to confirm with your insurance company that Dr. Johnson is currently in network with your plan. Premier Women's Care does not accept any form of Medicaid.

Initial_____ **Insurance Responsibility:** As the patient, you are responsible for knowing your insurance benefit coverage and whether a referral is needed. We will file your insurance claim as a courtesy to you. We allow 45 days from the date of service for the insurance to pay a claim. If your insurance company does NOT pay within this time, you will be responsible for the entire balance. As the insured you are expected to be aware of when or if a claim is paid by reading the **E**xplanation **O**f **B**enefits from your insurance company. This EOB will tell you what is owed to Dr. Johnson, or if you need to contact your insurance company to find out why they did not pay. Please understand we code our services based on the type of appointment scheduled and the problems covered during the visit. Once insurance has been filed, we will **NOT** change diagnosis or procedure code.

You have a contract with your insurance company, and we expect you to be involved in making sure your visit or surgery is paid for. You should be familiar with the answer to the following questions:

- Is Dr. Johnson in network with your plan?
- Does your plan have services that are not covered by insurance?
- Does your insurance require a co-payment for office visits? Is there a percentage of each visit you are required to pay?
- Does your insurance cover routine appointments and/or immunizations?
- Are you required to use any specific pharmacy?
- If you require lab tests or x-rays, are there certain labs/facilities you are required to use?
- If you require after-hours emergency care, are there certain hospital emergency departments you should use?

Initial_____ **After Insurance Pays:** Any remaining balance after your insurance pays is due within 30 days, regardless of whether you have received a statement from Premier Women's Care. Statements are sent out monthly. You have access to your EOB from your insurance company either online, by telephone, or by mail. Your EOB will show the amount you owe to Dr. Johnson.

Initial_____ **Secondary Insurance:** We will NOT file a claim to your secondary insurance. You are responsible for the entire amount due based on your primary insurance. You will receive an EOB from your primary insurance, you can mail that EOB along with a receipt from Premier Women's Care and any other necessary forms to your secondary for reimbursement.

Initial_____ **Check-In/Check-Out:** Please bring your current insurance card to EACH VISIT. Without your insurance card, we will not be able to file your insurance and you will be required to pay for the charges for services rendered that day. We will give you a receipt and you will be able to request reimbursement from your insurance company. At each follow up visit, you will be required to verify the information on your demographics sheet so that our information remains up-to-date. We will collect your copay, deductible, or coinsurance at the time of service. We accept cash, checks, Visa, Mastercard, and Discover. We accept American Express only on balances over $1000.00. A $50 fee is charged for returned checks.

Initial_____ **Past Due Balances:** You will not be able to see the doctor until all past due balances are paid. Please be prepared to pay for your current visit as well as any past balance at the time of service.

Initial_____ **No Show/Late Cancellations:** We require 24 hour advance notice if you must cancel an appointment. Any patient not cancelling 24 hours in advance will be charged a $50 fee. If you so not show up for an appointment without calling, you will be charged a $50 fee. Each additional cancellation/no-show will increase to $75. Procedure and Surgical no-shows will result in a $75 fee. There are no exceptions.

Initial_____ **After Hours Calls:** After-hours calls should be limited to emergencies only. Calls for prescription refills, questions about minor illnesses, over-the-counter drug doses, etc., should be made during office hours. Dr. Johnson cannot be available at all hours for **non-emergency** questions. If the doctor feels that an after-hours call is inappropriate, the physician may remind you that such a call should be made during office hours. **Inappropriate after-hours calls will result in your being charged for the doctor's time.**

Initial_____ **Practice Dismissal:** Occasionally, we may find it necessary to dismiss a patient from the practice. Reasons for this include, but are not limited to, the following: recurrent late or missed appointments; noncompliance with recommended medical care; nonpayment of bills; threatening, abusive, or rude behavior toward office staff, doctors, or other patients and families.

Initial_____ **Minors:** The parent or guardian seeking medical attention for the minor is responsible for providing current information for the minor and payment for services provided. Unaccompanied minors must have a handwritten authorization for medical treatment by the parent/guardian before treatment is rendered.

Initial_____ **Outstanding Balances:** Balances over 90 days will be sent to Frost-Arnett Company, a collection agency. It is your responsibility to contact our business office if there are extenuating circumstances regarding your account before your account is turned over to Frost-Arnett.

Patient's Printed Name: _____ DOB: _____ Date:_____

Responsible Party's Signature: _____ DOB:_____ Date:_____