



Financial Policy

In an attempt to keep our patients informed and to ensure proper reimbursement for services rendered, we ask that you carefully review the following, ask any questions you have, initial next to each section, and sign in the space provided. A copy can be provided at your request. Everyone's insurance coverage is different, **knowing your insurance benefits is your responsibility**. Please contact your insurance company with questions you may have regarding your coverage. The phone number for this can be found on the back of all insurance cards.

_____ **Insurance Coverage:** We currently participate with most major insurance plans. You should always contact your insurance provider to confirm that we are participating with your plan and are in-network. It is your responsibility to make sure you have updated insurance information at the time of the visit, or you will owe payment in full for the visit.

You are responsible for all insurance denials regarding "incorrect insurance information" provided to us.

If you have an HMO insurance plan, please make sure to change us to the PCP before your appointment. We will file your insurance claims on your behalf with the information you have provided to us. Knowing your insurance benefits, co-pays and deductibles are your responsibility. Problems relating to your coverage should be handled between you and your insurance provider.

_____ **Copayments, Coinsurance, and Deductibles:** **ALL** copayments and deductibles must be paid at the time of service. Balances may be collected at the time of service as well. We may have to bill your insurance to see what your responsibility is: it is your responsibility to pay this portion of your bill. We do have payment plans that can be set up if you are unable to pay the balance in full.

_____ **Non-covered Services:** Please be aware that some of the services you receive may be considered non-covered or not medically necessary by your health plan. You will be financially responsible for these charges.

_____ **Guarantor:** The parent or guardian who signs the patient's paperwork is the party responsible for all charges and payments. If this person is to change, please inform us immediately so we can make changes to the account.

_____ **Claim Submissions:** We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly that we may not be able to. It is your responsibility to comply with their request. Please be aware that the balance of your claim. Failure to provide them with information to get the claim paid will result in the outstanding balance becoming your personal responsibility.

_____ **Nonpayment:** All outstanding balances are to be paid upon receipt of the statement. Payment is required for past-due balances prior to your next visit. After 3 statements, or if your account is over 90 days overdue, your account will be sent to an outside collection agency for further collection efforts. You will be responsible for the outstanding account balance and all collection fees that are incurred from this agency. If you

are sent to collections, you and your immediate family members may be discharged from this practice. If this occurs, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period our providers will only be available to treat you on emergency basis.

_____ **Returned Checks:** If your payment is made by check and it is returned by the bank for insufficient funds, you will be required to pay a fee of \$35.00.

_____ **Cancellations and No-Show Appointment Policy:** Scheduled appointments may be canceled up to 24 hours in advance of the appointment. We understand that there are times when you may miss and appointment due to emergencies or obligations due to work or family. **One no-show appointment will be excused.** You will receive a phone call reminder that you missed your scheduled appointment. Any future missed appointments will be charged a **\$25.00 fee** and you will be sent a bill for this. If you have over 3 missed appointments, you may be dismissed from this practice.

_____ **Forms and Letter Completion Policy:** Forms that are completed during an office visit, or related to an office visit, will be completed free of charge. Other forms that are dropped off to be completed, or lengthy complex forms, will be charged a **\$15.00 form completion fee**. This fee is to be paid at time of pick up. **No FMLA forms will be filled out without an appointment** and must be an established patient of the practice prior to the form being filled out.

_____ **Medical Records Request Policy:** Maryland code § 4-304 regulates fees for provision of medical records. You will be charged \$0.75 per page for the first 50 pages, and \$0.25 per page beyond 50 pages, the cost of shipping and handling or any applicable postage, as well as a \$10.00 search and handling fee. It may take up to 2 weeks to provide a complete medical record, so if needed, contact our office as soon as possible.

I have read, fully understand, accept, and agree to comply with all the above policies. I agree to comply with any future amendments to these policies. I consent to the assignment of authorized health insurance benefits by my health insurer to Pleasant Valley Primary Care for any services furnished to myself or family member and understand that failure to make payments in a timely manner may result in collection fees.

Patient Name (Printed)

Date

Patient Signature