HUSSNY FAMILY PRACTICE PAYMENT POLICY

We are committed to providing you with the best possible care, and will help you receive your maximum allowable insurance benefits. *However* we need *your* assistance and understanding of our payment policy. Please read it, ask any questions, and sign in the space provided. A copy will be provided upon request. Your insurance contract is between you, your employer and the insurance company. **Knowing your insurance benefits is your responsibility. Please contact your insurance company with questions you may have regarding your coverage.**

1.Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. As a courtesy to you, we will file a claim with your insurance carrier on your behalf. Any remaining balance will be billed to you once we have received a remittance from your insurance carrier.

2. Co-payments, co-insurance and deductibles. ALL co-payments, co-insurance and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, co-insurance and deductibles from patients can be considered fraud. Please help us in upholding the law by paying these fees at each visit.

3. Non-covered services. Please be aware that some, and perhaps all, of the services you receive may be noncovered or not considered reasonable or necessary by your insurer. You must pay for these services in full at the time of your visit.

4. Proof of Insurance. All patients must complete our patient information forms before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance 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 the claim.

5. Claims submission. We will submit your claims and reasonably assist you in getting your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. *If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.*

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. Nonpayment. *A fee pf $35* will be charged for check returned for insufficient funds. **A $5 fee will be charged each month a statement is not paid in full.** If your account is *over 90 days past due* your account will be sent to an *outside collection agency* for further collection efforts that will **also incur added collection fees which you will be responsible for.** If you are sent to collections, you and your

immediate family members may be discharged from this practice. If this is to occur, 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 physician will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge for missed appointments not cancelled **with at least 24 hour notice**. These charges will be your responsibility and billed directly to you. The fee for a missed appointment is **$25.** Missed procedure appointments, physicals, PAP and pre-op appointments will incur a **$50** charge. Please help us to serve you better by keeping your regularly scheduled appointment.

9. Forms, letters, and reports. We do charge for forms that are not completed during an office visit. The fee for completion of these items is based upon the complexity of the form and the time required in preparation. All fees must be paid in full before the forms can be returned to you.

10. Prescription Fee. If for any reason your prescription for medication, radiology, labs, etc.. needs to be rewritten, there will be a **$10 charge.**

11. Medical Records. To obtain copies of your medical records, you must sign a Medical Release form. There is a **$10** office fee, **plus $0.50 per page**. If we mail the records, there is a **$5** certified mail fee. These fees, set forth by Virginia State Law, must be paid in full before your request can be processed. Please allow **two weeks** for processing.

Patient Financial Agreement

TO SUBMIT CLAIMS TO MEDICARE: I request that payment of authorized Medicare and/or Medigap benefits be made either to me or on my behalf to Hussny Family Practice, HFP, for any services furnished to me by HFP. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I further authorize any holder of Medicare information about me to release to my Medigap Insurer any information needed to determine these benefits payable for related services.

TO SUBMIT CLIAMS TO INSURANCE: I hereby authorize, HFP, to apply for benefits on my behalf for covered services rendered by the practice, and request that the payments are made directly to HFP. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information, for this or any related claim. I permit a copy of this authorization to be used in place of the original. All co-payment, co-insurance and deductibles are due at the time of service.

NON-PAYMENT: I understand that if my account is turned over to a collection attorney or agency for non-payment, I will be responsible for any additional fees as allowed by law.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. **I have read and understand the**

payment policy and agree to abide by its guidelines. I have provided the practice with true and correct insurance information and will notify you of any changes in my health insurance coverage.

Signature of patient or responsible party Date

Printed Name