

Patient Financial Policy

Prime Care Family Practice is committed to providing high-quality, comprehensive family health care and personal service to our patients. For every commitment, there is an obligation. It is the patients' responsibility to meet their financial obligations. As we see patients from many different insurance plans, it is impossible for us to be certain of all the covered benefits, copays, and deductibles for each individual plan. While it is our intention to assist you, it is still your responsibility to ensure that all services rendered or referred by Prime Care Family Practice on your behalf are paid in full. To clarify Prime Care's Financial Policy, we have listed below our financial requirements:

Insurance Billing

Charges incurred for services rendered are the patient's responsibility regardless of insurance coverage. As a courtesy, Prime Care will submit claims to your primary and secondary insurance carrier for the medical services that we provide to you or your dependents. Please realize that having secondary insurance does not necessarily mean that your services will be 100% covered. Secondary insurances typically pay according to a coordination of benefits with the primary insurance.

To properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Remember, it is your responsibility to provide us with accurate insurance information and to inform us of any changes in your coverage as they occur. We accept many insurance plans but cannot guarantee their coverage of services or payment.

Copays, Coinsurance and Deductibles

Copays, coinsurance, deductibles, and non-covered services are due at the time of service and will be collected upon check in by the registration staff. We accept cash, debit card, check (except starter checks), Visa, MasterCard, Discover and American Express. If we make an exception due to an emergent circumstance and allow you to be seen without paying your co-pay at the time of service, there will be a billing fee of \$15.00 added to your account. We ask that you pay your co-payment and the billing fee within fifteen (15) days. This exception is only made for patients whose accounts are in good standing.

Uninsured or Self-Pay Patients

Payment is required at the time of service. Uninsured patients will receive a "same-day discount" which is a 10% discount on their charge. Without knowing the exact care that will be provided prior to the actual visit, self-pay patients will be required to pay \$95 towards the visit and will be asked to make payment arrangements for the balance. New patients and patients that are scheduled for a physical or procedure must pay \$120 towards the visit and will be asked to make payment arrangements for the balance. Extended payment arrangements are available if needed. Please ask to speak with a billing coordinator to discuss a payment plan. The billing department can be contacted by calling 804-526-1111, option 3, Monday – Friday from 8am until 5pm. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

Balance Owed or Past Due Accounts

Unless an acceptable payment plan has been made with our billing department, account balances are to be paid in full by your statement due date. If you fail to keep the terms of your payment plan without contacting us further, we will be forced to turn your account balance over to an outside collection agency. If your account is turned over to a collection agency, you will be responsible for a collection fee

of \$20. If efforts progress to stage 2, a 50% fee will be added to your account to include the additional collection fees. Please be advised that there is a finance charge of 1.75% per month on all past due balances.

Patient Payment Responsibilities

It is the patient's responsibility to understand his/her benefits and to keep us informed of any changes. Ask your insurer about any policy exclusions, including pre-existing conditions and verify deductible amounts. You should also verify your plan coverage for physicals, immunizations, and preventative services. This helps us better accommodate the patient at time of service and helps the patient to better anticipate any out-of-pocket expenses.

Please note, even if they cover an annual physical, your insurance company may not pay for additional problems that are addressed during the well exam. For physical exams or annual wellness visits that require additional services beyond the scheduled physical, an additional charge will be incurred, and you will be responsible for payment of the resulting copay, coinsurance, or deductible amount.

The patient or his/her legal representative is ultimately responsible for all charges for services rendered. Please call your insurance company directly if you are unsure whether a service is covered by your plan.

NSF/Returned Checks

There is a \$30 fee for any check returned by the bank. If a check is returned on your account, we will no longer be able to accept checks and your account will be made cash/credit only.

Missed Appointments, Cancellations and Late Arrivals

There will be a missed appointment charge of \$30 if you fail to cancel your appointment within 24 business hours prior to the scheduled appointment. After the third occurrence, any patient who fails to cancel an appointment may be discharged from practice.

Patients who arrive more than 15 minutes after their scheduled appointment time will be asked to reschedule. New patients are asked to arrive 30 minutes prior to their scheduled appointment time and will be rescheduled if they fail to arrive on time.

Refund

In the event an overpayment was made, the refund will be issued to the appropriate party. Patient refunds will not be processed until all active or past due balances are paid in full. Refunds are processed at the end of each month. Please call our billing office if you have any questions regarding this policy.

I understand and agree with the Financial Policy of Prime Care Family Practice.

Our practice is committed to providing the best treatment for our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

Patient Name: _____ **DOB:** _____

Patient/Guardian Signature: _____ **Date:** _____