

Spring City Health Centre Payment Policy

We are ready and equipped to file insurance claims for all most services rendered at our office. Our policy regarding the payment of accounts and the filing of claims is as follows:

It is expected that complete, up-to-date, and accurate insurance information have been provided. At the time of service, the patient (or Guardian) is expected to pay all co-pays. We would appreciate the payment of anticipated deductible/coinsurance responsibilities, if possible.

If you need to cancel your appointment, please do so as soon as possible. **We reserve the right to charge you \$50.00 if you do not cancel 24 hours in advance. For missed lab or testing appointments there is a \$25.00 charge. For some visits we may ask that you send a \$75.00 deposit to hold your appointment,** depending on the type of visit you are scheduling.

Regardless of payment source, it is required that all accounts are paid in full within 60 days of date of service to remain current. Monthly statements should be reviewed and any questions brought to our attention.

Patients will usually find themselves in one of the following **three categories**. Payment exceptions are outlined below.

A. In-Network covered services will be billed to insurance company (IC) or third party administrator (TPA) with the exception of any co-pay due at the time of service. We appreciate every effort made to have co-pays paid at the time of service. It is the patient's responsibility to see that their IC or TPA is not causing their account to become past due. We cannot be responsible for disputes regarding insurance coverage (as providing zero interest loans is not a sustainable component of the practice of medicine).

B. Out of Network covered services will be billed to the IC or TPA. Deductibles and co-insurance responsibilities will not be subject to discounts. We offer a 10% discount on office visits if payment is made at the time of service. If this discount is given for prompt payment, reimbursement from the payer will be directed to the patient.

These first two categories pertain to covered services only. Charges for non-covered services can be discounted from the insurance-based price if it is known at the time the services will be non-covered, either from previous determination or due to refusal by the IC or TPA to pre-authorize the service. This discount cannot be given after the claim for services has been submitted and deemed non-covered. It is understood that determination of covered vs. non-covered services is difficult due to the complexity and number of insurance products available.

C. Patients without insurance, those participating in high deductible insurance products or those having signed a private contract outside of the Medicare system have the option of identifying themselves as a cash paying patient and thereby receive a discount on both covered and non-covered services. Claims for services will not be submitted to the IC or TPA. Patients are expected to keep their accounts current as above, ideally paying at the time of service in order to allow us to continue these discounts. Patients will receive receipts for all payments made and monthly statements on outstanding balances.

Patients will get the most accurate information regarding in vs. out of network status by calling their insurance company and sharing our Federal Tax ID number, available by calling the office

Medical care provider by phone, email or non-office settings will not be billed to the IC or TPA. Charges will be added to the patient's account and appear on the monthly statement.

We appreciate the confidence you have placed in us as we help you attain optimal health. Please ask us any questions you may have regarding our financial policy.

Dr Glenn A Toth, MD

I have read and understand the above policy. I agree to be financially responsible for those portions of my bill which are not "covered services" or are deemed to be "not medically necessary".

Patient / Guardian Signature

Date

Print Name of Patient