

Mtn. View Family Practice, P.C.

Payment Policy and Patient Responsibility

Thank you for choosing us as your primary care provider. We are committed to providing you quality and affordable health care. Please read the following policies, initial each section, and sign below in the space provided. A copy will be provided to you upon your request.

1. **INSURANCE.** Knowing your insurance benefits is your responsibility. We participate with some, but not all insurance companies. If you are not insured by a plan we do business with, a minimum deposit will be required for each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, a minimum deposit (\$75/New Patient, \$50/Established Patient) will be required for each visit until we can verify your coverage. Again, knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding coverage.

Initials _____

2. **CO-PAYMENTS AND DEDUCTIBLES.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Co-payments and deductibles are patient responsibility. Failure on our part to collect co-payments and deductibles from patients is in violation of contract agreements. Please help us in upholding our contracts by paying your co-payment prior to each visit.

Initials _____

3. **NON-COVERED SERVICES.** Please be aware that some or all of the services provided to you during your visit may not be covered by your insurance company. Any unpaid services are patient responsibility and payment may be required in full at the time of the visit.

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4. **PROOF OF INSURANCE.** All patients must complete the patient registration form before receiving any services through our facility. We also require a copy of a valid photo ID, such as state license, and a copy of your current insurance card as 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 in full.

Initials _____

5. **CLAIMS SUBMISSION.** Your insurance benefit is a contract between you and your insurance company. As a courtesy to you, we will submit claims to both primary and secondary insurance. Some insurance companies require patients to submit information directly and if so, this is your responsibility to do so in a timely manner. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Any unpaid balances remaining 60 days after claims have been submitted to your insurance become your responsibility.

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6. **COVERAGE CHANGES.** It is important to notify us as soon as possible of any changes pertaining to your insurance coverage. Failing to do so may result in unpaid claims and you may be responsible for the balance of the claim in full.

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7. **UNINSURED/SELF-PAY PATIENTS.** If you are seeking medical services at our facility and do not have insurance, a minimum deposit is required for each visit - **\$75.00 for new patient appointments and \$50.00 for Established Patient appointments.** The minimum deposit will most likely not cover all services provided during the visit and if so, you will receive a bill for the remaining balance owed. In addition, we offer **Financial Assistance** to uninsured patients who apply and meet the eligibility guidelines. Eligibility is based on household size, income, assets, and expenses. If you are interested, please speak with our front desk staff or the Billing Department.

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8. **MOTOR VEHICLE ACCIDENT (MVA).** If you are receiving treatment as a result of a MVA, you are responsible for paying a \$100 deposit for Established Patients and \$200.00 for new patients, plus all costs of treatment not reimbursed by the Personal Injury Protection (PIP) coverage. If your motor vehicle accident claim is in dispute, all costs are due at the time of service.

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9. **WORKERS COMPENSATION (WC).** If you are receiving treatment for a work injury we will bill your work comp carrier. If your claim is denied, we will bill your regular medical insurance carrier pursuant to ORS 656.313. You will be required to pay all amounts not covered by your medical insurance, co-

payments and deductibles. If your claim is ultimately resolved against you by both Work Comp and Medical Insurance, you will be required to pay all amounts due within 60 days. If you do not have medical insurance coverage, you must assume full responsibility for the cost of your care and a deposit of \$250.00 will be required at the time of service.

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10. **ON-CALL/AFTER HOURS.** After hours paging is **FOR EMERGENCIES ONLY**. Non-emergency calls may result in a \$45.00 charge billed directly to you, the patient, based on review by the medical provider on call.

Initials _____

11. **PRESCRIPTION REFILLS.** If you are in need of a prescription refill, you must call your pharmacy at least **48 hours** prior to running out of your medication. If you have no further refills remaining, your pharmacy will contact us directly to request additional refills. Please note - our on-call providers may not be able to refill medications during evening and weekend hours.

Initials _____

12. **PHONE CONSULTS.** Phone consults are not covered by medical insurance. If you would like a phone consult by one of our medical providers, the charge is **\$45.00** and will be billed directly to you, the patient. This needs to be paid prior to the consult, unless other satisfactory arrangements have been made with the billing department.

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13. **NONPAYMENT.** If your account is over 30 days past due and arrangements have not been made, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless satisfactory arrangements have been made with our billing department. If balances remain unpaid, we may refer your account to a collection agency, which will result in up to 40% of the unpaid balance in additional collection fees. In addition, if you pay with a check and your check is returned, your account will be charged a **\$25.00 Returned Check Fee**.

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14. **MISSED APPOINTMENTS.** We require a 24-hour notice on all appointment cancellations. Our policy is to charge for missed appointments and failure to cancel more than 24 hours in advance may result in a **\$45.00** fee, billed directly to you, the patient. The **\$45.00** fee must then be paid prior to receiving additional service through our facility. If you fail to keep an appointment due to unforeseen circumstances, please discuss with our billing department. After two or more missed or late appointments, your account will be reviewed and you may be discharged from our facility as a patient.

Initials _____

15. **TERMINATION.** This is a Private Practice in Family Medicine. Dr. Paul Podett, Clinicians and staff strive to create a pleasant working environment. We understand that there are times when patients may be frustrated due to your current symptom(s) or personal situation(s). We will make every attempt to help you. However, this practice, under no circumstances, will tolerate physical or verbal abuse of any kind, for any reason. **Abuse in any form is grounds for immediate discharge.** In addition, to avoid further conflict, the office may choose to discharge a patient and family members.

Initials _____

16. **PAIN MANAGEMENT.** **Our providers do not treat or manage chronic pain.** The American Pain Society define "chronic pain" as - *generally considered to be pain that lasts more than 6 months, is ongoing, is due to non-life-threatening causes, has not responded to current available treatment methods, and may continue for the remainder of the person's life.* If you are suffering from chronic pain, your provider will discuss with you other options for seeking treatment.

Initials _____

I have read and fully understand the policies written above.

Patient Name (Print)

Date

Patient or Legally Authorized Representative Signature

Legally Authorized Representative (Print)

Relationship to Patient