

## Crystal Coast Family Practice, PA Financial Agreement

**INSURANCE:** We participate with Medicare, Medicaid, Tricare, FEP-BCBS, BCBS of NC, and State Employee Plans as well as several other commercial carriers, including Aetna, CIGNA, PHCS/Multi-Plan and others. Since insurance policies vary greatly in what they cover, it is **YOUR** responsibility to:

- Verify that the provider you are scheduled with is actively participating with your insurance carrier.
- Know your benefits, what services are covered and what is non-covered.
- Know your financial responsibility in terms of co-pay, percentage of co-insurance and deductible not met.
- Ensure that all pre-approval requirements are met to avoid denials or out-of-network benefits.

Your insurance policy is a contract between **YOU** and your insurance company. In the event that our provider is not currently participating with your plan, perhaps some or all of the services provided may be non-covered and you will be 100% responsible for the charges. Our fees are not based on the amount your insurance company will pay. The amount approved by your insurance company on a particular procedure may be more or less than our standard fee.

According to NC Statute 58-3-225, insurers are required to pay a properly submitted claim within 30 days. It is **YOUR** responsibility to provide the correct information to our office so a claim can be properly submitted. Most often, errors in billing are related to incorrect information. It is **YOUR** responsibility to promptly furnish requested information to your insurance company. Many time claims are delayed because the subscriber has failed to respond to a request for information from their carrier. If either the practice or the plan fails to receive accurate information to process your claim, you will be held responsible for the charges. **Payment not received in 60 days from your insurance company may transfer to patient responsibility and you will be responsible for payment.**

If we receive payment at a later date, you will be refunded by Crystal Coast Family Practice.

**CO-PAYMENTS, CO-INSURANCE AND DEDUCTIBLES:** Many plans require that a patient pay a co-pay at each visit. We will collect your co-pay at check in. If your co-pay or deductible is not paid at check-in, a fee of \$10.00 will be added to your account. If your visit is for a non-urgent reason, you may be asked to reschedule your appointment. To avoid collection issues and unnecessary billing expenses, we will collect at the time of service any percentage co-insurance or deductible not met. The amount calculated is based on our negotiated fee schedule with the carrier or our standard rates if we are out of network.

**CREDIT CARD ON FILE:** We now offer credit card on file for flexibility and convenience. This allows you to store your credit card, HSA and FSA information in an encrypted and PCI-compliant manner.

**UNINSURED:** If you do not have health insurance, payment in full is expected at the time of service. It is our policy to collect a deposit of \$195 for new patients at **check-in**. If at the time of check-out, your charges were less than the \$195, you will be immediately refunded. If your charges at check-out exceed the amount of your deposit, payment will be due at that time. We collect a deposit of \$127 for established, uninsured patients.

**DELINQUENT ACCOUNTS:** An account is considered delinquent if the statement is not paid by the next billing cycle. (Just like your electric, cable and cell phone bills.) We will make attempts to contact you by phone and mail. Failure to pay will result in your account being turned over to an outside collection agency and a \$35 administrative charge will be added to your account. If your account is referred to a collection agency, we will no longer offer medical care to the guarantor of the account or any family members for whom that guarantor is responsible.

**BANKRUPTCY:** Accounts written off due to bankruptcy will also result in termination from our practice. However, you may work with your Bankruptcy attorney to draft a letter expressing your intent to pay our bill and continue as a patient.

**RETURNED CHECKS:** We charge a \$25 fee for returned checks. In addition, future payments must be made by cash, credit card or money order. Failure to redeem a returned check within 5 days will result in the same action as a delinquent account.

**SMALL BALANCES:** We do not send statements for balances \$10.00 or less. However, we will notify you at your next appointment and will expect payment at that time.

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**MISSED APPOINTMENTS:** No-show and appointments cancelled less than 24 hours in advance may result in a \$50 charge posted to your account. This will not be filed, nor will it be paid by your insurance company. This is your responsibility.

**PAYMENT METHODS:** We accept cash, checks, American Express, Discover, Visa and Master Card. You may use the convenience of our patient portal to make an on-line payment. We also offer a service that will enable you to ALWAYS keep your account current, without the hassle of statements by mail, etc. AUTO-PAY allows us to charge your credit card account when a balance is due. For more information, call our billing office at (252) 247-1200. Or you may send a secure message through the patient portal to "Ask a Biller".

**MOTOR VEHICLE AND LIABILITY CLAIMS:** We do not file with third party payers for motor vehicle or other accidents. We do not make arrangements with any attorneys to hold your billing until a court case is settled. Payment in full is expected at the time of every visit.

### **ACKNOWLEDGEMENT & ACCEPTANCE OF FINANCIAL AGREEMENT:**

*The acknowledgement and acceptance of the financial agreement will be displayed on the Phreesia pad used at check in with your signature required at that time. This copy is for informational purposes only. I understand I am financially responsible for all charges not paid by my insurance, including non-covered services, out of network charges, co-pays, co-insurance, and deductibles. I understand that it is my responsibility to keep my insurance and demographic information current. I understand that my payments on any balance due must be paid within 45 days of the statement date. Failure to do so will result in my account being delinquent. I understand that delinquent accounts past due 90 days or more may be sent to an outside collection agency, unless prior arrangements have been made with a Patient Account Representative.*

### **Authorization and Assignment of Insurance Benefits:**

*I authorize Crystal Coast Family Practice to release any and all of my medical records or the records of my minor child(ren) and/or any other information and records required by my insurance company or its designated review agents who provide benefits on my (our) behalf needed to process claims on my (our) behalf. This includes, if applicable, my employer and/or employer's workmen's insurance company in the case of a work related illness, the Social Security Administration or the Centers for Medicare & Medicaid Services. I request that payment made for medical services for myself and/or dependents be made on my behalf to Crystal Coast Family Practice, PA. I permit a copy of this authorization to be used in place of the original.*

### **Medicare Assignment of Benefits Statement:**

*I request that payment of authorized Medicare and/or any other government sponsored insurances of which I may be covered, be made on my behalf to Crystal Coast Family Practice, PA. I also assign any Medigap benefits to be paid directly to my provider.*

*This authorization and assignment of benefits will be displayed on the Phreesia pad used at check in with your signature required at that time. This copy is for informational purposes only.*