SHELBY MEDICAL ASSOCIATES
PATIENT FINANCIAL POLICY

Thank you for choosing Shelby Medical Associates for your medical care. We value you as a patient and look forward to serving your healthcare needs. A good understanding of financial expectations is part of every physician-patient relationship. The following is our financial policy.

We accept the following forms of payment: cash, check, debit card, MasterCard, and Visa.

INSURANCE

• Our practice follows all insurance company required rules. If we participate with your plan and you are eligible for benefits, we will file your charges with your insurance company.
• Your insurance company requires we collect all patient payment responsibilities. Therefore, you will be expected to pay your co-payment, co-insurance and/or deductible amounts at the time services are rendered or your appointment may be rescheduled. Additionally, patients will be responsible for non-covered services the patient approves.
• In the event a lab, test or procedure is done, we will estimate your payment responsibility. You may be asked to pay your estimated payment at the time of your visit. Once your insurance has paid, you will be billed or refunded any difference between what you paid and the amount due after the insurance payment.
• If your insurance plan requires pre-certification or a referral or treatment authorization, it is ultimately your responsibility to ensure that the proper referral has been obtained. Any treatment without the necessary referral may result in a denial of payment by the insurance company, making payment for all charges your responsibility.

UN-INSURED

•If you do not have medical insurance, you will be responsible for payment of 50% of estimated charges at check-in plus any previous outstanding balance. If you cannot make this payment, your visit will be rescheduled, or you will be referred to the community health clinic. If a lab, test or procedure is necessary, 50% payment will be required prior to the procedure. We offer a 25% discount for payment in full at time of service.

MEDICARE

• We are a participating provider with Medicare. As an added service, if you have coverage secondary to Medicare, we file that for you. ***Your co-insurance and deductible amounts will be due at time of service or your appointment may be rescheduled.***

MEDICAID

• We are a participating provider with North Carolina Medicaid; however you must have your current card with you at time of service. Your card must have remaining visits to be valid. Please note that we do not accept managed care/HMO Medicaid, without proper authorization.

WORKERS COMPENSATION

• We will file your workers compensation claim as long as we have authorization for the services. If there is no authorization on file, payment is due when services are rendered.

OVERDUE ACCOUNTS

• We reserve the right to charge a fee for overdue accounts. ***If you need ongoing medical care, we expect payment on your old balance as well as payment in full for new charges at the time of service.*** Unresolved patient account balances will be turned over to a professional collection agency unless you are making timely payments on an approved payment plan.

NO SHOWS & CANCELLATIONS

•Please call ahead if you are unable to keep an appointment. 24 hours prior notice is required. We reserve the right to charge a fee for appointments that are missed or that are cancelled with less than 24 hours notice. If three (3) appointments are missed or cancelled without prior notice, you may be discharged from the practice.

***** PLEASE SIGN THE ACKNOWLEDGEMENT PAGE *****

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT FINANCIAL POLICY

√ I have read the Patient Financial Policy and understand the policy.

√ I agree to pay at time of visit all co-pays, coinsurance and deductibles due for the visit, and to promptly pay all outstanding patient balance for services provided to me and/or my family.

√ All insurance payments for services rendered are assigned to this office. (A copy of this assignment is as valid as the original).

√ I understand that it is my responsibility to contact my insurance company should a claim be denied or not paid in full.

√ I understand that charges may occasionally be added or modified by my provider due to required corrections to services rendered or insurance claims billed.

√ I understand that I am financially responsible for all charges, whether or not they are covered by my insurance.

√ I authorize this clinic to release to my insurance carrier any medical information needed to obtain payment for services rendered.

√ I understand that if I disagree with any charges, I will contact this office in writing within 30 days of the billing date.

√ Should legal action be taken by this office to collect an unpaid balance due for medical services provided, I agree to pay reasonable attorney's fees or other such costs as the Court determines proper.

NOTICE: Do not sign this agreement before you read and agree to the conditions set forth in the Patient Financial Policy. You should keep a copy of this agreement in your records.

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PATIENT SIGNATURE DATE