REGENCY HEALING MEDICAL CLINIC

Healing And Preserving Our Community

Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part your contract with your insurance company. Failure on your part to collect co-payments and deductibles from patients can be considered fraud.

3. **Non-covered services.** Please be aware that some – and perhaps all- of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. If this is the case, we will explain all non-covered services and their cost before any testing is performed. You will be asked to sign a form stating your understanding.

4. **Proof of Insurance**. All patients must complete our patient information form before seeing the doctor. We will need a copy of your driver's license and current valid insurance card to provide 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.

5. **Claims Submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to contract.

6. **Coverage change.** If your insurance changes, please notify us before your next visit so we can make the appropriate change to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **Nonpayment.** If your account is over 90 days past due, it will be placed with a collection agency. Once placed in collections, all fees incurred in collecting the debt, including any legal fees, will be added to the patients balance, and become the responsibility of the patient or guarantor. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, you and your immediate family members may be discharged from the practice. If this were to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis. Please initial here after reading, number7. _____

8. **Missed appointments.** Our policy is to charge $25 for each missed appointment not cancelled within 24 hours. This charge will be your responsibility and billed directly to you. After three no show appointments, you will be dismissed. After three no show appointments, you will be dismissed from the practice please help us to serve you better by keeping your regularly scheduled appointments.

9. Our practice is committed to providing the best treatment to 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. I have read and understand the payment policy and agree to abide by its guidelines.

_____ _____

Signature of Patient or responsible party Date: