SHAKER URGENT CARE (AND FAMILY PRACTICE)
FINANCIAL POLICY

Shaker Urgent Care PC believes that communicating our financial policy is good healthcare practice. Charges incurred for services rendered are the patientôs responsibility regardless of insurance coverage. Your insurance coverage is a contract between you and your insurance company, not your insurance company and us. We will file your primary and secondary insurances as a courtesy. Please realize that having secondary insurance does not necessarily mean that your services are covered 100%. Secondary insurances typically pay according to a coordination of benefits with the primary insurance. It is your responsibility to provide us with accurate insurance information and to inform us of any changes in your coverage as they occur.

You are responsible for all copays, coinsurance, deductibles, and non-covered services. We are obliged to collect your copay at the time of service per your insurance company. We accept cash, debit card, check, (except starter checks & not from new patients), MasterCard & Visa. Statements are sent out monthly, and we ask that balances due be paid when you receive your statement or at your next appointment, whichever is sooner. Patient payments are typically applied to the oldest balances first, except for copayments and coinsurances ï they are applied to the current date of service. There is a $30.00 returned check service charge. Payment will then need to be made by cash, money order or credit card for the balance due.

When you receive healthcare services from us and we bill your insurance, it is the same as though we are extending you credit. You receive the service and we await payment from you and/or your insurance. Due to the high cost of rendering care and the lowering reimbursements by many insurers, including Medicare, we simply cannot afford to carry large balances. Balances not paid within 90 days will be turned over to an outside collection agency, unless prior payment arrangements have been made and of course a service fee will be generated.

Completing disability forms, FMLA forms, and other requested supplemental insurance forms requires a prepayment of $15.00 per form. We request that you allow 3 business days for this process.

I understand and agree to Shaker Urgent Care, PC Practice Financial Policy.

Print Name_____ Date_____
Signature_____

Shaker Urgent Care, PC FINANCIAL POLICY DEFINITIONS & DETAILS

Please be assured that everyone in this practice is dedicated to providing medical care of the highest quality possible to all of our patients, in an atmosphere of caring, trust and mutual respect.

Your complete understanding of your financial responsibilities is essential; it takes a team that includes patient participation, to succeed with insurance processing and reimbursement. Failure by the insurance company to pay will result in the balance being transferred to the patient for payment.

In order to become a ñproviderò of medical services through your health plan, the providers at Shaker Urgent Care are required to enter into a contract with selected insurance companies.

Things to bring with you to your visit:

- Health Insurance Card ï
- Drivers License
- Method of payment ï for your convenience we accept cash, checks (except starter checks) Visa & MasterCard

Assignment of Benefits:

Shaker Urgent Care will only bill contracted insurance plans as a courtesy to our patients provided that the patient has provided the required insurance information in a timely manner and has signed a current financial policy.

Appointment cancellation, rescheduling and no-shows

- We schedule and confirm appointments.
- If you do not show for your appointment, cancel or reschedule within 24 hours of your appointment time, we will bill you an administrative fee of $25.

Additional Testing:

For Family Practice preventative care exams, the provider may request you to undergo certain additional screening tests. Please contact your insurance company to determine if these are covered benefits to avoid incurring charges for which you will be held responsible.

13-18 years: pap testing, screening lab work (CBC, CHEM, TSH, CRP), gonorrhea, chlamydia screening, mental health benefits (libido issues, depression, anxiety ï these are considered ôMental Health Issues by Insurance Companies and may not be covered if you do not have ôMental Healthô Benefits)

19-39 years: screening lab work (CBC, CHEM, TSH, CRP), gonorrhea, chlamydia screening, baseline mammogram at age 35, mental health benefits (libido issues, depression, anxiety)

40-64 years: yearly mammograms, bone densitometry, colonoscopy referral after age 50, screening lab work (CBC, CHEM, TSH, CRP), mental health benefits (libido issues, depression, anxiety)

65& above: yearly mammogram, bone densitometry, screening lab work (CBC, CHEM, TSH, and CRP), mental health benefits (libido issues, depression, and anxiety), and pap smear every 2 years unless risk factors exist. Please instruct your physician if you wish to have the pap completed yearly at your expense.

CASH/SELF PAY

You will be notified at the time of service what charges will likely be incurred for your visit, noting that additional testing may need to be completed after examination. You may also be asked to purchase orthotics, which are not be covered by your insurance plan. Should you not wish to purchase your crutches, splints, etc., you will be given an order for your orthotics to be taken to a durable medical equipment supplier in order to be covered by insurance.

Charges for copies of medical records

You will be charged for copies of medical records. These charges cover the administrative costs of copying and mailing such records.

In Pennsylvania, these fees are set by ACT 26 and they allow us 30 days to process your request.

Checks

We gladly accept checks as a form of payment. We do not accept starter checks.

We charge a $30 returned check fee. If a check is returned on your account, you will no longer be able to write checks.

Payment will then need to be made by cash, debit card, money order or Visa & MasterCard.

Co-pay and co-insurance:

- We are obligated to collect the co-pay at the time of your visit, even if you are sick. We are required to do so by your insurance plan. The co-payment amount is determined by your individual insurance policy.
- All payments are due at time of service.
- If a situation arises and your co-payment is not paid at time of service, your account will be assessed $10.00 for the cost of creating an invoice

Deductibles:

ÅSome insurance plans require that patients pay a predetermined dollar amount prior to services being covered. ÅDeductibles processed by your insurance company are due by your next visit or billing statement which ever procedure comes first

FMLA and other Disability Paperwork

ÅThere is a charge of $15 per form, payable prior to these forms being completed.

Health Savings Accounts / Healthcare Debit Cards:

- If we are contracted with the health insurance with which you have this kind of plan, we may only bill you the full amount of our contracted allowable fee.
- We ask that you do not ask us to bill you for services rendered, we will require payment in full at time of service.

Insurance:

- We are contracted with multiple insurers to accept assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the authorized co-payment, co-insurance and deductible at the time of service.
- If you have insurance coverage under a plan with which we do not have a contract, you will be treated as a cash pay patient and will be provided documentation to assist you in filing your claim

- If we are unable to verify your benefits, we will ask that you pay for your visit.

Laboratory, Radiology and other diagnostic services bills

ÅPlease check with your insurance company to verify what your schedule of benefits allows for any laboratory, x-ray or other diagnostic studies (bone densitometry, mammogram, etc.) that may be ordered by the doctor during your visit. *These services will be billed separately by the laboratory/ diagnostic facility that does these tests and are not covered by the payments that you make at this office.* Any insurance claims or problems associated with an off-site laboratory must be dealt with through that facility or their billing agent.

Medicare Patients

- Please make sure you have a full understanding of your Medicare benefits and what might be your responsibility if not covered by Medicare.
- *Your doctor wants to diagnose a condition you may have or evaluate how well your treatment is working. To do that the doctor needs to have certain diagnostic tests performed. The doctor will tell you what those tests are and why they are necessary. Before your tests are performed, you may be asked to sign an Advanced Beneficiary Notice or "ABN".* ***Why do we ask you to sign the ABN?*** We ask patients to sign an ABN whenever Medicare appears likely to deny payment for a specific service. Medicare requires that we provide patients with a written notification whenever it is likely that you will be responsible for the bill.

Motor Vehicle Accidents

- We do submit claims to motor vehicle insurances.
- You cannot be seen without the name and address of your insurance company, claim number and date of accident
- If your services are declined, we then will submit the claim to your personal health insurance along with the letter of declination. However, the patient is ultimately responsible for any denials, copayment, coinsurance or deductibles
- It is the patient responsibility to know if we accept or are on the panel of their personal health insurance.

Out of Network:

- Full payment is due at time of service.
- Appropriate claim documentation will be provided for filing with the insurance company.

Outstanding balances/ Collections:

Prior to providing additional services to you, payment in full of total outstanding balances will be required.

- Outstanding balances will be referred to an outside collection agency. Once we receive an EOB (explanation of medical benefits) from your insurance, we will mail to you a statement. If we do not receive payment within a reasonable time, your account will be referred to a collection agency and a $25.00 fee will be accessed to your account.

Patient Responsibility:

- Minor Patients: For all services rendered to minor patients, we will look to the accompanying adult for payment.
- Understanding of benefits: It is the patientôs responsibility to call their insurance company and determine what your schedule of benefits allows and what services they will and will not cover.

Payment Responsibility:

- The patient or his/her legal representative is ultimately responsible for all charges for services rendered.
- ñNon-coveredò means that a service will not be paid under your insurance contract. If non-covered services are provided, you will be expected to pay for these services at the time they are provided, or at the time of receiving a statement or EOB from your insurance provider denying payment.

Refunds are issued to the appropriate party. Patient refunds will not be processed until all active or past due charges are paid in full.

Well visit and Problem/sick visit on the same day

Some insurance companies will cover well visits and some will not. It is your responsibility to know what healthcare benefits your insurance covers, prior to your visit. If you need to discuss any health problems that require evaluation and management, this must be documented and appropriately billed for. Your insurance company may not pay for additional problems that are addressed during the well exam. During your discussion with your provider, they will manage your problem first and may ask you to make another visit for you well exam.

Workers Compensation Visits

- At appointment time, you will be required to have the name and address of your workers compensation carrier along with your claim number
- If Workers compensation declines your claim, we will then bill your health insurance along with the declination. The patient is responsible for any co-payment, co-insurance, deductible as well as making sure we accept their personal health insurance.