Sample Patient Payment Policy

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

For your convenience, we have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a Billing Specialist or the Practice Manager.

How May I Pay?
We accept payment by cash, check, VISA, Mastercard, American Express and Discover.

Do I Need A Referral?
If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, we have a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled.

Which Plans Do You Contract With?
Please see attached list.

What Is My Financial Responsibility for Services?
Your financial responsibility depends on a variety of factors, explained below.

Office Visits and Office Services

If You Have...	You Are Responsible For...	Our Staff Will...
Commercial Insurance Also known as indemnity, "regular" insurance, or "80%/20% coverage."	Payment of the patient responsibility for all office visit, x-ray, injection, and other charges at the time of office visit.	Call your insurance company ahead of time to determine deductibles and coinsurance. File an insurance claim as a courtesy to you.
HMO & PPO plans with which we have a contract	If the services you receive are covered by the plan: All applicable copays and deductibles are requested at the time of the office visit. If the services you receive are not covered by the plan: Payment in full is requested at the time of the visit.	Call your insurance company ahead of time to determine copays, deductibles, and non-covered services for you. File an insurance claim on your behalf.
HMO with which we are not contracted.	Payment in full for office visits, x-ray, injections, and other charges at the time of	Provide the necessary information for you to complete and file your

If You Have...	You Are Responsible For...	Our Staff Will...
	office visit.	claim directly with the insurance company.
Point of Service Plan or Out Of Network PPO	Payment of the patient responsibility—deductible, copay, non-covered services—at the time of the visit.	Call your insurance company ahead of time to determine out of network benefits, copays, deductibles, and non-covered services. File an insurance claim on your behalf.
Medicare	If you have Regular Medicare, and have not met your $100 deductible, we ask that it be paid at the time of service. Any services not covered by Medicare are requested at the time of the visit. <u>If you have Regular Medicare as primary, and also have secondary insurance or Medigap</u>: No payment is necessary at the time of the visit. <u>If you have Regular Medicare as primary, but no secondary insurance</u>: Payment of your 20% copay is requested at the time of the visit.	File the claim on your behalf, as well as any claims to your secondary insurance.
Medicare HMO	All applicable copays and deductibles at the time of the office visit.	File the claim on your behalf, as well as any claims to your secondary insurance.
Worker's Compensation	<u>If we have verified the claim with your carrier</u> No payment is necessary at the time of the visit. <u>If we are not able to verify your claim</u> Payment in full is requested at the time of the visit.	Call your carrier ahead of time to verify the accident date, claim number, primary care physician, employer information, and referral procedures.
Worker's Compensation (Out of State)	Payment in full is requested at the time of the visit.	Provide you a receipt so you can file the claim with your carrier.
Occupational Injury	Payment in full is requested at the time of the visit.	Provide you a receipt so you can file the claim with your carrier.
No Insurance	Payment in full at the time of the visit.	Work with you to settle your account. Please ask to speak with our staff if you need assistance.

Surgery

If your physician recommends surgery, you will be escorted to his Surgery Coordinator. She will answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved, and complete all pre-certification/authorization if your insurance company requires it.

The Surgery Coordinator will request a pre-surgical deposit, the amount of which depends on your coverage and deductible amount. A cost estimate which shows your financial responsibility, based on the benefit levels and coverage of your insurance plan, will be explained by the Surgery Coordinator.

What if My Child Needs to See the Physician?
A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying adult is responsible for payment of the account, according to the policy outlined on the previous pages.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to (name of your practice).

I authorize (name of your practice) to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

_____	_____	_____
Date	**Signature**	**Printed Name**

Pre-Authorized Use of Credit Card

I authorize _____
(name of healthcare provider)
to keep my signature on file and to charge my Visa / Mastercard for:

☐ Balance of charges not paid by insurance within 90 days and not to exceed $_____ for:

☐ this visit only.

☐ all visits this year.

☐ Recurring charges (on-going treatments or payment plan) of $_____

every _____ from _____ to _____.
(frequency) (date) (date)

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the healthcare provider.

_____
Patient Name

_____
Cardholder Name

_____
Cardholder Address

_____
City State Zip

_____
Credit Card Account Number Expiration Date

_____
Cardholder Signature Date

PAYMENT PLAN

Patient's Name:_____ Date: _____

Balance:_____ Owed to:_____
(Doctor or Practice Name)

The above-named patient (or guarantor) agrees to make monthly payments on the balance of this account. Payments will be made on or before the _____ day of each month. Failure to meet this obligation will make the agreement null and void and the practice will then reserve the right to make a "Demand For Payment" on the remaining balance.

Minimum monthly payment agreed upon: $_____

The account will be paid in full on or before:_____
(Date)

ALL FURTHER CHARGES WILL BE PAID AT THE TIME OF SERVICE

_____ _____
Signature (Patient/Guarantor) Date

_____
Signature (Authorized Employee)

Employee: Document the date account is paid in full_____

NOTES:

INSTRUCTIONS: Original to patient; copy to chart

COLLECTION

LETTERS

Initial Collection Procedure (Soft Approach)

XYZ Medical Clinic
Any Street
Anytown, USA 90001

May 1, 19--

Mr. John Smith
800 Your Street
My Town, CA 90010

Dear Mr. Smith:

The current balance of your account has been brought to my attention. After reviewing the account, I urge you to contact our office immediately to make financial arrangements.

If you are experiencing a set of circumstances out of your control, a reasonable monthly payment plan is available to you so you can satisfy your obligation and keep your account in good standing.

I have instructed our staff to make every effort available to you to satisfy any misunderstanding you might have concerning your balance. I look forward to your personal interest and cooperation in this matter.

Sincerely,

Administrator Signature

Initial Collection Procedure (Firm Approach)

XYZ Medical Clinic
Any Street
Anytown, USA 90001

May 1, 19--

Mr. John Smith
800 Your Street
My Town, CA 90010

Dear Mr. Smith:

My collection coordinator recently brought to my attention your current balance. After reviewing your account, I urge you to contact our practice immediately and do not hesitate to ask our staff for financial assistance. Our staff is more than willing to assist you.

If you are experiencing economic hardship, a reasonable payment plan is available so you can satisfy your obligation and keep your account in good standings. I have instructed our staff to make every effort available to you to satisfy any misunderstanding you might have concerning your balance.

All patient accounts are due and payable within thirty (30) days of services rendered. Refusing to establish financial arrangements will force us to consider limiting future credit to you until all previous account balances are paid in full.

I am looking forward to your personal interest into this matter and your cooperation in resolving it quickly.

Sincerely,

Administrator Signature

Financial Arrangement

XYZ Medical Clinic
Any Street
Anytown, USA 90001

I have reviewed all charges for services rendered. My balance of _____, to my knowledge is correct. Beginning on _____, I agree to _____ payments of _____, due on the _____ day of each month. I understand my account will be considered delinquent if my scheduled payment is more than 4 days late. I understand that I will be legally responsible for all collection costs involved with the collection of this account including all court costs, reasonable attorney fees, and all other expenses incurred with collection if I default on this agreement. I have read the above description of arrangement and agree to its terms.

_____ _____
Patient's name and signature Date

_____ _____
Authorizing signature for practice Date

Failed Arrangement Procedure

XYZ Medical Clinic
Any Street
Anytown, USA 90001

May 1, 19--

Mr. John Smith
800 Your Street
My Town, CA 90010

Dear Mr. Smith:

Recently it has been brought to my attention that you have failed to make your scheduled monthly payment to our practice.

As a matter of policy, I am offering you the opportunity to remit immediate payment as previously agreed. Our practice appreciates your personal interest in this matter.

If you fail to comply with our request we will be forced to return your account back to a delinquent credit status.

I urge you to contact our practice as soon as possible to avoid any alternative collection actions. If you have any further questions, please call our practice and ask for assistance. I am looking forward to our cooperation in this matter.

Sincerely,

Practice Administrator

Secondary Collection Procedure (Soft Approach)

XYZ Medical Clinic
Any Street
Anytown, USA 90001

May 1, 19--

Mr. John Smith
800 Your Street
My Town, CA 90010

Dear Mr. Smith:

Our practice requires full payment when services are rendered.

As a courtesy to our patients, we offer confidential financial counseling and reasonable monthly payment plans to those patients who might require assistance. I am offering you the opportunity to avoid any further unpleasant collection actions by making the effort to contact our practice as soon as possible. Our practice will require a written financial agreement for payment.

Your immediate attention in this matter will determine if you will be granted future credit. My office manager has been advised to make every effort available to you. I sincerely hope it will not become necessary to proceed beyond this letter and that you will cooperate with our request.

Sincerely,

Administrator Signature

Secondary Collection Procedure (Firm Approach)

XYZ Medical Clinic
Any Street
Anytown, USA 90001

May 1, 19--

Mr. John Smith
800 Your Street
My Town, CA 90010

Dear Mr. Smith:

Recently our practice informed you by letter that we would be forced to limit your future credit with our practice if you failed to establish financial arrangements.

Unfortunately, today I am instructing our credit manager to limit your future credit with our practice until you make the effort to contact us and establish an appointment for financial arrangements. If you are experiencing economic hardship, a reasonable payment plan to accommodate your current financial status if available.

Ignoring this letter is not in your best interest. I have instructed our credit manager to make every effort available to you to satisfy any misunderstanding or disagreement you might have concerning your owed balance. I am looking forward to your cooperation in this matter.

Sincerely,

Administrator Signature

Final Demand Letter (Soft and Firm Approach)

XYZ Medical Clinic
Any Street
Anytown, USA 90001

May 1, 19--

Mr. John Smith
800 Your Street
My Town, CA 90010

Dear Mr. Smith:

I am writing you today since our repeated requests for payment have been ignored. According to our records, your balance remains unpaid to our practice.

I have instructed my credit manager to make every effort available to you to satisfy any misunderstanding you have concerning your owed balance. A reasonable payment plan is available to you if you make the effort to contact us immediately. I hope you realize this unfavorable credit information might effect your future opportunities of being granted credit nationwide. This information could be reported to future employers, insurers, and financial institutions on request.

I am deliberately withholding any action on your account for the next seven days. If we do not receive any response from you, I will be forced to consider an alternative action. I hope you will avoid this action by contacting our practice immediately to make financial arrangements and payment.

Sincerely,

Practice Administrator