MASA
MIDWEST ALLERGY SINUS ASTHMA sc

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**WE KNOW THAT CHOOSING A PHYSICIAN IS A VERY IMPORTANT DECISION AND WE THANK YOU FOR CHOOSING OUR OFFICE. PLEASE TAKE A MINUTE TO CAREFULLY READ THIS OVERVIEW OF SOME OF OUR FINANCIAL POLICIES.**

## REQUIRED AT CHECK-IN/OUT

- Verify Personal Contact Information
- Present Current Copy of Insurance Card
- Present Current Picture ID
- Payment of any Outstanding Balance
- Payment of Today's Visit

We will use our best efforts to verify your coverage at each visit. If we are unable to do so, you will be considered self-pay and will be responsible for your visit balance.

## CLINIC DEPOSIT

A deposit of $30.00 is required for New Patient appointments at the time of scheduling to confirm and hold your clinic appointment. This deposit will be applied to your account balance. Missed appointments without at least 24 hours advanced notice of cancellation or rescheduling will forfeit your deposit.

## INFORMATION REGARDING YOUR INSURANCE COVERAGE

Health insurance coverage varies significantly by carrier, by employer, and/or by contract. Your insurance policy is a contract between you and your insurance company. It is your responsibility to know and understand your plan coverage benefits. Our staff cannot guarantee what any insurance company will cover and any statements made by members of our staff regarding insurance coverage of visits or procedures is not a guarantee and does not shift the responsibilities explained in this document onto our practice. We suggest you contact your insurance company prior to services being rendered so that you are aware of your potential financial responsibility. Following are a list of things you should verify:

- Provider is in network
- Facility is in network – this includes our office and any other facility you may choose to receive services ordered by our office (lab, radiology, etc.).
- Referral or precertification required
- Out of Pocket Expense – Co-pay, co-insurance, deductible, etc.
- Diagnostic testing (labs, radiology, etc.)
- Procedure/testing benefits
- Pharmacy network and prescription benefits

In some instances, MASA may perform and bill for a service, however another provider and/or facility may perform and/or bill for another component of that service (radiology interpretation,

facility fees, laboratory fees, etc) in which you will receive a separate bill in which you are responsible for.

It is also your responsibility to provide our office with all required information regarding your health insurance coverage. It is important that you promptly notify us if there are any changes to your insurance information. If any complications arise during the billing process, you have an obligation to promptly provide assistance and information to our billing office (internal and/or external) and if your failure to timely provide this information or assistance results in a denial of coverage, you may (in certain circumstances) become personally responsible for paying for the services.

**UNINSURED PATIENTS**

If you do not have current health insurance coverage, the entire payment for any services performed shall be paid at the time of service.

**NON-PARTICIPATING PROVIDER OR NON COVERED BENEFITS**

If we do not participate with your health insurance carrier, or if the services provided are not covered under your particular health insurance plan, then you are responsible for paying for all services at the time of service. If you would like us to do so, we can (upon your request and full payment) provide a statement for your records and/or reimbursement purposes.

**PARTICIPATING PROVIDER AND COVERED BENEFITS**

If we participate with your health insurance carrier and the services sought are covered services under your particular health insurance plan, then we will directly bill your health insurance carrier. Under your plan, you may be responsible for paying certain amounts (e.g., **co-payments, co-insurance, deductibles and fees for non-covered services**), which **are due at the time of service**. In the event these fees are not paid at time of service, a **$3.00** billing convenience fee will be charged. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our specialty. You are responsible for the appropriate contracted or billed charges regardless of your insurance company's arbitrary determination of usual and customary rates. Whether your insurance pays or not, you are responsible for the appropriate balance.

**TYPES OF PAYMENT; DISHONORED CHECKS**

Our office accepts ***cash, personal checks, Master Card and Visa***. If your check is dishonored (e.g., refused for insufficient funds), you will be required to pay an additional fee of **$30.00** which shall be due immediately.

**COLLECTION OF OUTSTANDING BALANCES**

All outstanding balances shall be due within 30 days. Unless we have agreed to other payment arrangements in writing, it is important that you pay all past due balances, in their entirety, prior to or at the time of your visit. Failure to pay your account balance in full within 30 days of the statement date will result in a ***1.5%*** monthly late fee. Balances that remain outstanding for a period of 90 days or more may be referred to a collection agency or attorneys' office. If your account is referred to a

collection agency, you will be responsible for paying a collection charge equal to ***35%*** of your outstanding balance, which is in addition to your outstanding balance and any applicable interest. If your account is referred to an outside attorney, you will be responsible for paying all reasonable attorneys' fees and court costs, which are in addition to your outstanding balance and any applicable interest.

**MISSED APPOINTMENTS**

It is important that you appear for all scheduled appointments. Your failure to cancel or reschedule an appointment in a timely manner (i.e., at least 24 hours prior to the visit) deprives other patients of an opportunity to visit our office. You will be responsible for a paying a missed appointment fee of **$30.00** if you fail to appear for a scheduled visit and have not provided at least 24 hours advanced notice of cancellation or rescheduling. This policy is aimed at minimizing the waiting time and ensuring availability of prompt medical care. Established patients who miss three appointments without proper notice will be terminated from the practice.

**SERVICE FEES**

Certain services (e.g., medical records copy, phone consultations, completing forms, producing narrative reports, personal letters, etc.) may not be covered by insurance and are due at time of service. Prior to requesting any such services, you should request a copy of our **miscellaneous services fee schedule**.

**By signing below, patient or responsible party acknowledges that he or she has read and understood MASA's Financial Policy and agrees to be bound by the terms and conditions set forth therein. I understand that charges not covered by my insurance company are my responsibility.**

**I authorize Midwest Allergy Sinus Asthma, SC to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim. I authorize my insurance benefits to be paid directly to Midwest Allergy Sinus Asthma, SC.**

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**Signature of Patient or Responsible Party** **Date**

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**Print Name of Patient and Responsible Party (if any)**

_____ _____

**Signature of Co-Responsible Party** **Date**

_____

**Print Name of Co-Responsible Party (if any)**

_____ _____

**Witness (Office Staff) Signature** **Date**