Bloomington-Normal Office 309-452-0995
Springfield Office 217-717-4404
Satellite Offices: Carlinville-Morton-Sherman-Jacksonville-Taylorville

FINANCIAL POLICY

We know that choosing a physician is a very important decision. We thank you for choosing our office. Please carefully read this overview of our financial policies. Every case and insurance is different and not all policies that apply to you may be listed. We are happy to assist with any questions you have.

CHECK-IN and CHECK-OUT We require:

- Verification of Personal Contact Information
- Current Copy of Insurance Card
- Current Picture of ID
- Payment of any Outstanding Balance
- Payment of Today's Visit
- Social Security Number (If Required by Your Insurance for Claims)

We will use our best efforts to verify your coverage at each visit. If you do not provide the items needed to process your claim or delay in doing so, we will not be able to submit to insurances for payment and you will be considered self-pay and will be responsible for your visit balance. Please be mindful that we work hard to provide you excellent healthcare and deserve to pay our staff their wages for honest work. Please bring all the required information to each and every office visit. If a balance exists with our office, our front office staff will ask you to pay your due portion, including copays, deductibles, and co-insurances, each time you visit.

SCHEDULING A NEW PATIENT VISIT

MASA collects a NoShow / Cancellation Fee at the time of scheduling your first appointment with us. A fee of $30.00 is required to confirm your appointment and will be applied to your account balance after your first visit. Missed appointments without at least 24 hours advance notice of cancellation or rescheduling will forfeit the full fee. We implement this fee in order to reduce No-Show and No-Call appointments, since we have reserved the time for your care. Another patient cannot be seen during this time slot unless you give us enough notice.

INFORMATION REGARDING YOUR INSURANCE COVERAGE

Initial

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 your financial responsibilities. We suggest you contact your insurance company prior to services being rendered so that you are aware of your potential financial responsibility. It is your responsibility to provide our office with all required information regarding your health insurance coverage. Please 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). If you do not, you may be denied coverage and may become personally responsible for paying for the services yourself in full.

Initial

For labs and x-rays, it's your responsibility to know which facilities are in-network for your plan. Please let your physician know where you would like these to be performed at.

The following are a list of things you should verify:

- Our provider/doctor 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 pre-certification requirements -- some HMO’s will require you to be referred by your primary care doctor and some insurances will require an authorization before certain tests are performed.
- Your Out-of-Pocket expense – such as co-pay, co-insurance, deductible, etc.
- Preferred Diagnostic Testing Facility (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.

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. We do our best to provide care to all patients of all means. Please inquire about our scaled fees for uninsured patients.

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 the 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

Our office accepts ***cash, personal checks, MasterCard and Visa.***

COLLECTION OF OUTSTANDING BALANCES

All outstanding balances shall be due within 30 days. Unless we have agreed to other payment arrangements in writing, please 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.

Initial

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 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 advance notice of cancellation or rescheduling. This policy is aimed at minimizing the waiting time and ensuring the availability of prompt medical care. Established patients who miss three appointments without proper notice may be terminated from the practice or will be required to pay a $30 booking fee at the time of making an appointment.

Initial

AFTER HOUR PROVIDER CALLS

We are available to you for care after hours and during scheduled office closures, such as holidays. For after hours or weekend calls, we assess a **$30.00** fee for services rendered. These services may be performed by telephone, email, text message and video chat. This fee is not covered by insurance, and is **due at the time of service** .

Initial

REMOTE SERVICES / PHONE CONSULTATIONS

Many of our patients travel fair distances to see our allergy and immunology experts. We also want to respect your time. If you cannot attend an office visit in person, are traveling and need remote assistance, or would prefer to have a telephone, email or video consultation with the doctor or advanced practice provider, we can schedule such services in advance at a time convenient for your. We assess a fee of $50.00 per 15 minute block for remote services. This fee may not be covered by insurance, and will be **due at the time of service** if not covered by insurance.

Initial

SERVICE FEES

Certain services may not be covered by insurance and are due at the time of service. Prior to requesting any such services, you please request information for our **miscellaneous services fee schedule.** Some of our services are noted below:

Billed to Insurance or $30	Physician physician-to-physician phone communications for your care
$30	Abbreviated Doctor Letters for special services or accommodations for work, school, universities, etc.
Per page +Fee	Personal copy of medical records
Per page +Fee	Medical records for court cases
$50	Forms, e.g. FMLA, 504 School Plans, Disability
$50/15 minutes	Personal or Narrative Healthcare Reports or Letters
$30	Dishonored check fee for insufficient funds, Due immediately

By signing below, the 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 the payment of a claim. I authorize my insurance benefits to be paid directly to Midwest Allergy Sinus Asthma, SC.

_____	_____	_____
Print Name of Patient	**Name of Responsible Party** (if any)	**Date**
_____	_____	_____
Signature of Patient	**Signature of Responsible Party** (if any)	**Date**