well&you

a better way to care

PATIENT FINANCIAL POLICY

We, on the Well & You team, welcome you to our practice. We would like to thank you for choosing Dr. Murthy and our clinical care team as your healthcare provider. Our practice is committed to providing you with the best possible medical care. One of our goals is effective communication with our patients, their families and/or caregivers.

The following is a statement of our Financial Policy, which we ask you to read, sign, and return to the reception desk prior to the beginning of your treatment. We believe a clear understanding of our Patient Financial Policy is important to our relationship. Please understand that payment for services provided by our clinical care team is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities.

Your Responsibility

You are financially responsible for the services we provide to you. We understand that many patients arrange for insurance companies to pay for a large portion of medical claims. However, the patient is ultimately responsible for the bill if your insurance company does not pay.

For Our Patients with Medical Insurance Benefits

We participate in most major health plans, including Medicare. Our business office will submit claims for any services rendered to a patient who is a member of one of these plans and will assist you in any way we reasonably can to help get your claims paid. If you have a secondary insurance, we will automatically file a claim with them as soon as the primary carrier has paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

Please bring your insurance card and a photo ID with you at the time of your appointment. If you are insured by a plan that we are contracted with, but don't have an insurance card with you, payment in full for each visit is required until we can verify your coverage.

In order to properly bill your insurance company, we require that you provide all insurance information, including primary and secondary insurance, as well as any change of insurance information since your last visit. Failure to provide our office with complete insurance information may result in patient responsibility for the entire bill.

The insurance company makes the final determination of your eligibility and benefits. If your insurance company denies any of your medical claims, you agree to pay all balances. If your insurance company pays you directly, you are responsible for payment of our fees and agree to forward the payment to us within (5) days of receipt. Any balance remaining after insurance has paid their part of the covered portion will be due from the patient upon receipt of our insurance statement.

Medicare

Our office will submit your Medicare charges to Medicare and your secondary insurance, when applicable. You are responsible for deductibles, co-pays and any non-covered services. If you do not have secondary insurance, we will collect your 20% co-pay at the time of service.

Non-Covered and Out of Network Services

Medical services that are considered by your insurance company to be non-covered, out of network, or not medically necessary will be your responsibility for full payment. If we are not in-network with your insurance company and your insurance pays you directly, you are responsible for payment of our fees and agree to forward the payment to us within (5) days of receipt.

For Our Patients with No Medical Insurance

If you do not have group or individual medical insurance, payment for all professional services is expected at the time of your visit. Please note, we do offer discounted fees for patients without health insurance.

Referrals

If your insurance company requires a referral from your primary care physician, you are responsible for obtaining it. 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. Failure to obtain the referral may result in a lower or no payment from the insurance company, and the balance will be your responsibility.

Coverage Changes

Please advise us of any address, phone number or insurance changes promptly to help maximize your benefits. Failure to do so may result in your insurance company not being responsible for your care, and you will subsequently be held financially responsible for paying out of pocket. ***Co-Payments***

Co-payment and deductible amounts are determined by your insurance company. Your insurance company requires us to collect co-payments at the time of service. Please be prepared to pay your co-payment and any outstanding balance from prior services rendered, at each visit. For your convenience we accept cash, checks,

Visa, MasterCard and American Express. If you do not have your co-payment your appointment may need to be rescheduled.

Waiver of Patient Responsibility

It is the policy of the practice to treat all patients in an equitable fashion related to account balances. The practice will not waive, fail to collect, or discount co-payments, co-insurance, deductibles, or other patient financial responsibility in accordance with state and federal law, as well as participating agreements with payers.

Insurance Pre-Authorizations

Our office will contact your insurance carrier for a pre-authorization for all medical or surgical procedures prior to treatment. This may take a few days or weeks for your insurance company to complete. *A pre-certification, prior authorization, or pre-determination of benefits is not a guarantee of payment. It is an acknowledgement from your insurance carrier that they deem the recommended treatment plan as medically necessary services and is subject to coverage at the time of service*.

It is ultimately the patients' responsibility to know their insurance benefits. Therefore, we recommend that the patient also contact their insurance company to verify recommended treatments are covered under your policy and not treated as a policy exclusion. Our business office will provide you with procedure and diagnosis codes needed to verify with your insurance company. ***Patient Appointment Responsibilities***

Your appointments are determined by a member of the clinical care team to optimize the results from your treatment plan. In addition to the clinical benefit of a structured appointment schedule, the schedule makes it possible to assure that the appropriate medical personnel and clinical care staff, as well as the required medical equipment and facilities, are available to complete your treatment safely and effectively.

Delinquent Balance Appointment

Patients with a delinquent balance are required to make payment in full for future services. A delinquent account is defined as a patient balance in excess of 60 days if the patient has not made any payments or sought assistance via financial hardship during this time. If such payment is not made, services may be refused.

Late Arrivals

A patient who arrives more than 15 minutes after his/her appointment is considered a late arrival. A late arrival, not considered to be the responsibility of the Practice, will be registered and worked into the schedule as soon as possible. If the patient is more than 30 minutes late, the appointment may need to be rescheduled.

Missed Appointments

As a courtesy to our patients, we will call you to remind you in advance of your upcoming appointment. Our staff will contact you at the telephone numbers you have listed on your patient registration forms.

We make every effort to honor all time commitments and request that you extend the same courtesy to us by letting us know at least 24 hours in advance if you are unable to keep your appointment. Any patient who fails to arrive for a scheduled appointment without notifying the practice at least 24 hours prior to their scheduled time, is considered a "no-show". *Excluding emergencies*, *any patient canceling a procedure without a 48 hour notice in advance may be charged a $200.00 cancellation fee*. A patient who repeatedly fails to show up for scheduled appointments may be dismissed from the Practice.

Returned Checks

The charge for a returned check is $25.00 and payable only by cash, money order or credit card. This will be applied to your account in addition to the amount of the NSF check. You may be placed on a cash only basis following any returned check. Please be aware that our bank may try to process your NSF check a second time; in this case there will be (2) $25.00 returned check fees assessed to your account.

Terms of Payment: All balances are due within 30 days of the statement date. You may pay by cash, check, Visa, MasterCard or American Express.

Collection Procedures

Members of our billing department are always available to help you with questions and or payment arrangements. Once made in writing, agreements are binding. We consider payment by the patient for services rendered to be an important part of the patient's role in the patient & physician relationship. Prompt payment for services rendered is expected and failure to comply or respond to repeated communications from our office may result in discharge from the practice and/or involvement of an outside collection agency.

Once an account has been referred to an outside agency, prior balances must be resolved before being seen by our staff for additional services. We understand that medical care can often become very expensive. If you have concerns about your ability to pay for service, we recommend that you contact us for assistance in the management of your account.

Please let us know if you are having difficulty paying the balance on your account. We may be able to help you by setting up a payment plan based on your financial hardship.

Credit Card on File

The patient is advised to bring their insurance cards and that the practice requires a credit card be kept on file for guarantee of payment for co-pays, co-insurance, deductibles, and any balances after insurance pays. Thank you for taking the time to read and understand our Patient Financial Policy. Our practice believes good communication is essential in our relationship with our patients. Please let us know if you have any questions or concerns before signing below. Your signature indicates that you have read this policy and understand and agree to its terms.

(To Be Initialed by Patient Indicating Acceptance)

_____ Excluding emergencies, a fee of **$200.00** may be assessed to your account if a 48-hour advanced notice of cancellation is not given for any scheduled procedure. The practice requires a $250.00 deposit no later than 7 days prior to large vein procedures scheduled. These fees are not covered by insurance carriers or Medicare and will be your responsibility to pay. *An appropriate notice of cancellation provides us with the ability to schedule patients on our wait list. Our goal is to open otherwise unused appointment time for other patients needing care, not to collect missed appointment fees.*

_____ The practice requires a $50.00 nonrefundable credit card payment to schedule a cosmetic sclerotherapy appointment. The remaining balance is due the day of the procedure, prior to treatment.

Procedures

If your doctor recommends a procedure, we will answer specific questions about the procedure scheduling process and complete all pre-certification and pre-determination of benefits prior to treatment. The Insurance Coordinator will request a pre-procedure deposit, the amount of which depends on your coverage and deductible amount. An estimate of your financial responsibility,

determined by your policy benefits, will be reviewed and explained to you by our Insurance Coordinator.

(To Be Initialed by Patient Indicating Acceptance)

_____ *I have read, understand, and agree to the above Financial Policy.*

_____ *I understand that charges are to be paid in full at the time of visit for all non-covered services, including services that are not medically necessary or cosmetic, as determined by my insurance company.*

_____ *I understand that all applicable copayments and deductibles are my responsibility.*

_____ *I authorize my insurance benefits to be paid directly to the practice.*

_____ *I authorize the Practice to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.*