Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care. Please understand that payment of your bill is considered a part of your treatment. The following is provided to avoid any misunderstanding or disagreement concerning payment for services, tests, and supplies provided by our office(s).

INSURANCE

Our office participates with a variety of insurance plans. It is your responsibility to:

1. Bring your current insurance card to every visit and notify us of any changes regarding your insurance coverage.
2. **Be prepared to pay your co-pay, coinsurance and/or deductible at the time of service.** Payment may be made by cash, check, Discover, MasterCard, or Visa. All co-pays and deductible amounts owed are due at the time of service. If your insurance applies any of your charge to your annual deductible or coinsurance, that portion is due and payable by you at the time of service. If you have elected to use our practice and our physicians out of your network of coverage please check with your insurance regarding benefit levels. Your employer or provider of insurance determines your benefit coverage by contracting with a particular insurance company. If you have questions regarding your coverage, please speak with your human resources representative or use the payer web address listed on your card. It is your responsibility to understand your benefit coverage.
3. We will submit a claim to your insurance company for you through our in house billing department. Balances not paid per contract with your primary insurance company may be billed to your secondary insurance.
4. Understand that your insurance carrier can choose to assign benefits to Memorial Medical Group or your insurance carrier may make payment directly to you.
5. I understand and agree that I am financially responsible for all health care service charges that are paid to me directly by my insurance carrier.

PAYMENT DETAILS

We accept Cash, check, Discover, MasterCard, or Visa. We have the capability to accept payments over the phone with your debit or credit card account information. We reserve the right to process your payment electronically based on the information you provide us.

SURGICAL AND LABORATORY SERVICES

If you are having surgery at Memorial Hospital, the hospital and anesthesiology services are separate providers and will be billed separately from the office services provided to you. Laboratory services provided at our office are also provided by Memorial Hospital and will also be billed separately from the office services provided to you.

NON-COVERED SERVICES

If you are seeking a non-covered service, do not have insurance, or if you are covered by an insurance for which we are not a provider, we require that you be prepared to pay our fees at the time services are rendered. You may inquire with our staff about self-pay cash discounts for payment at the time of service.

If temporary financial problems affect timely payment on your account you may set up a payment plan.

Specific coverage issues should be directed to your insurance company's member services department (the number should be located on the back of your insurance card).

Our office(s) charges for all services that are significant and separately identifiable. Patients that are seen for physical exams and require treatment for illnesses or problems may be charged separately for each service when both are provided on the same day.

Our office(s) can only code and file a claim for a patient's visit with a diagnosis that was encountered and documented in the medical record.

COLLECTIONS

All balances billed are due upon receipt of a statement. Unpaid balances greater than 90 days are subject to our collection process.

RETURNED CHECKS

There is a $20.00 fee charged for all returned checks.

SMALL BALANCE POLICY

If a credit or due balance exists on your account equal to $9.99 or less, and is more than 90 days old, the account will be automatically adjusted according to our small balance policy. If you are seen within the 90 day period, the small balance will either be credited to your account or requested at the time of service. Following the 90 day period, we will not issue any refunds or send statements for balances equal to or less than $9.99.

APPOINTMENT CANCELATIONS/NO-SHOWS

If you cancel, miss or no-show for three (3) appointments you may be dismissed from the office(s) for not complying with the plan of care you and your physician(s) have discussed.

HIGH DEDUCTIBLE HEALTH PLANS (HSA, HRA, FSA PARTICIPANTS)

Please inform us prior to your visit if you are a participant in a High Deductible Health Plan (HDHP), a Health Savings Account (HSA), a Health Reimbursement Arrangement (HRA) or a Flexible Spending Account (FSA). You must be prepared with the plan information and pay the patient responsible portion from the HSA, HRA or FSA at the time of service.

MINOR AGED PATIENTS

Adults accompanying minor patients (parent or legal guardian) will be required to complete a Release of Liability and Permission Form. The parent or legal guardian is responsible for payment of any financial balances for that minor not covered by insurance. For unaccompanied minors, treatment will be denied unless the proper paperwork is received, and the insurance card lists the minor's name.
I have read, understand and agree with this Financial Policy.

CONTACT AUTHORIZATION

I authorize Memorial Hospital and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address provided.

Printed Name (Patient or Legal Representative):		**Date:**
Signature (Patient or Legal Representative):		**Date:**
	Office Staff Initials:	**Date:**

Memorial MEDICAL GROUP

CONSENT FOR TREATMENT

Patient Name: **Date of Birth:**

NOTIFICATION TO ALL PATIENTS

The rigid regulations of the insurance industry require us to have you sign the following release:

I agree to pay for any and all medical services I receive from the provider(s) of this office(s) that my insurance company refuses to pay, for whatever reason. This office(s) will file a claim on my behalf, however, if my insurance denies payment for any reason (i.e. non-covered services, does not pay for preventive medical visits, failure to secure a referral from my primary care physician, etc.) I will pay for the visit(s) upon written/verbal notice of their refusal. Failure to pay within 45 days of filing is for the purpose of this agreement and constitutes a refusal to pay.

I further agree and understand that this office(s) can only code and file a claim for my visit(s) with a diagnosis that was encountered and documented in my medical record. Thus to ask this office(s) to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and may result in a fraudulent act.

INSURANCE RELEASE

I hereby assign all medical benefits to which I am entitled to Memorial Medical Group in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount due as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fees, attorney fees, and all court and legal fees associated with the recovery of this debt. I hereby authorize Memorial Medical Group to release all information necessary to secure the payment of said benefits. A copy of this consent shall be considered as effective and valid as the original.

CONSENT TO TREAT

I do hereby consent to such treatment by the authorized personnel of this office(s) as may be dictated by prudent medical practice of my illness, injury or condition. I authorize this office(s) to download my prescription history and eligibility benefits prior to my visit(s) for the purposes of medical decision making and eligibility verification. This consent is intended as a waiver of liability for such treatment with the exception of negligent acts.

Responsible Party Signature:	**Date:**

HIPAA RECEIPT CONFIRMATION: I have received a copy of Memorial Medical Group’s *Notice of Privacy Practices*. Additional copies can be provided upon your request.

Responsible Party Signature:		**Date:**
	Office Staff Initials:	**Date:**