

**PATIENT PAYMENT POLICY**

The Ness City Medical Clinic would like to thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance-We participate in most insurance plans, including Medicare and Medicaid. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don’t have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your insurance.

2. Co-payments and deductibles-All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.

3. Non-covered services-Please be aware that some-and perhaps all-of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of the visit.

4. Proof of Insurance-All patients must provide a current insurance card at each visit. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission-We will submit your claims and assist you in any way we reasonable can to help get your claims paid. Your insurance company may need you to supply certain information to them directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes-If your insurance changes, please notify us so we can make the appropriate changes to help you receive your maximum benefits.

7. Payment Plans-If you are unable to pay your account in full the clinic does offer a payment plan. We will be happy to work with you in setting this plan up. Please note that accounts with balances up to $250.00 must be paid in full within 3 months. Balances from $300.00 to $500.00 must be paid within 6 months. Balances from $500.00 to $1,000.00 must be paid within 9 months. Any account balance over $1,000.01 must be paid within 12 months.

8. Nonpayment-After 2 monthly statements are mailed to you and no payment on your account has been made you will receive a letter stating that you will be turned over to a collection agency if you do not make a payment within 14 days of receipt of letter. Please be aware that if a payment is not made, we will refer your account to a collection agency. If your account is turned to a collection agency you and your family will not be seen in the clinic, by one of our providers, unless the visit is paid for in full at the time of service. Patients receiving monthly medication prescription(s) must be current on their account payments in order to receive their prescription(s).

9. If you are on a payment plan and miss one payment you will receive a collections letter, you have 14 days to submit a payment on your account. If no payment is received your account will be turned to the clinic’s collection agency. If further payments are missed your account will be turned over to the clinic’s collection agency, no collection letter will be sent to you.

The Ness City Medical Clinic is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

**I have read and understand the payment policy and agree to abide by its guidelines:**

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Printed name of patient or responsible party

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Signature of patient or responsible party Date

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Witnessed By Date