Barnabas Health
Medical Group

# FINANCIAL POLICY

We are dedicated to providing our patients with the best possible care and service, while keeping the cost to you from rising at unreasonable rates.

We ask for your help by understanding and cooperating with our **FINANCIAL POLICY.**

***It is important for you to understand that health insurance coverage is an agreement between you and your insurance company.***

**AND**

***Your doctor's bill for services provided is an agreement between you and your doctor.***

**YOUR RESPONSIBILITY:** Our Physicians participate with several insurance companies. It is ***your*** responsibility to call your insurance company to verify that the doctor you are seeing is participating.

If we do not participate with your insurance company, we will bill your insurance carrier as a courtesy to you; however, we will expect payment from you at the time of service. If you do not have valid insurance information, and we cannot confirm coverage, we will consider you a self-pay and ask for full payment at time of service.

All co-payments or payments for non-covered service are the patient's responsibility and will be collected by our staff at time of service.

**PRIMARY CARE OFFICES:** If you are required to pick a Primary Care Physician ("PCP"), be sure that you have chosen one of the Physicians in the office where you have an appointment. You must contact your insurance company prior to the appointment to make this PCP selection. If your insurance company requires referrals for services at a Specialist office, please allow five (5) business days for non-emergency services prior to seeing that specialist or facility. If you go to the Specialist office without a referral, you may be responsible for the entire bill.

**SPECIALIST OFFICES & REFERRALS:** If your insurance company requires a referral/authorization from the Primary Care Physician, be sure that you have obtained a valid referral/authorization prior to your appointment. If you do not have a valid referral/authorization, you may be asked to reschedule. You agree to be responsible for payment of your account regardless of referral status.

You understand that it is your responsibility to know and abide by the terms of your benefit coverage including but not limited to properly securing referrals for specialized care before making appointments. You also understand that you are responsible for full payment for services provided if you fail to supply the referral forms, when required.

**PAYMENT FOR SERVICES PERFORMED:**

1. Our office accepts Visa, MasterCard, American Express, as well as Cash, Debit Cards and Personal Checks for payment of services.
2. Any co-payments required by an insurance company must be paid at the time of service. This is an insurance requirement; we cannot bill you for these.
3. All payments are expected at the time of service. Should your account require the action of a collection agency, you would be financially responsible for all collection and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.

**RETURNED CHECK FEE IS $30**

**CHARGES TO ACCOUNT:** We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

**MISSED APPOINTMENT FEE:** Patients who do not show up on time for an appointment, reschedule, or cancel with less than 24 hours' notice will be charged a $25-$50 fee. A $150 fee will be charged for any test or new patient appointment missed, and $250 for any missed procedures. This charge will not be reimbursed by your insurance. Patients with three missed appointments may be asked to transfer their records to another doctor.

**FORMS FEE:** There is a charge for the completion of forms brought into the office without a patient visit. This does not include those that are completed at the time of visit or with the exception of disability forms. The fee for this service is $25 and will be completed within five (5) business days.

**TRANSFERRING OF RECORDS:** If you require a copy of your records, you must submit a request and pay a copying fee. You are authorizing us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history. The fee will be $1/page to a maximum of $100.

**RIGHT TO AMEND:** You understand and agree that BHMG may amend the terms of this Financial Policy at any time without prior notification to the patient.