PATIENT FINANCIAL POLICY

To All Patients,

The purpose of this document is to help patients understand medical insurance, eligibility, coverage, and medical services as well as to inform them about their financial responsibility

It must be understood:

- We render our services based on medical guidelines , not Insurance benefits
- Not all insurance companies/third party payers pay for all services, each policy has its own particular benefits regarding covered services, or amount of coverage
- All insurance companies state that verification of coverage is not a guarantee of coverage or payment. Actual benefits are determined by your insurance company after a claim is received
- Patients are responsible for **knowing** and **understanding** their own Insurance Policy, Eligibility and Coverage

Financial Responsibility:

- Patients are responsible for payment of **<u>outstanding</u>** balances (Deductibles, Co-insurance and non-covered services, etc.) at the time of service. Co-pays will be collected at the time of service.
- Patients are responsible for full payment on Deductibles, Co-insurances, Co-payments, services deemed as “not a benefit” and “non-covered” services
- Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. For minors, the parent who accompanies the minor for their first visit will be financially responsible for all charges incurred.
- Medicare patients may be asked to sign an Advances Beneficiary Notice (ABN) form as required by Medicare for certain services
- Changes in insurance coverage must be reported to our Billing Staff promptly.
- There is a $25 fee for Medical records requests. Payment for these records will be collected prior to records being released. If applicable, a complimentary copy of your records will be sent to the physician of your choice.
- Any appointment missed or not cancelled more than 24 hours in advance will incur a $75.00 charge
- Returned checks are subject to a $35.00 fee
- We reserve the right to turn any account over to a collection agency for collection if it is deemed that the account has been in default or noncompliance with this policy.
- By signing this document, the Patient or Patient’s Representative authorizes Alliance Obstetrics & Gynecology and its third party billing and/or collection service providers to use any and all information provided by the Patient or Personal Representative for contact, including cell phone, if required.

I hereby acknowledge that I have reviewed this policy and agree to the terms/conditions of the policy.

_______________________________ _______________________

Signature of Patient or Guardian Date

_______________________________ _______________________

Witness Date

1560 Turf Lane ❖ East Lansing, MI 48823 ❖ 517-484-3000