Financial Policy

Thank you for choosing Classen Family Medicine, LLC.

It is our policy that all fees including co-pays, and outstanding balances are due and payable at time of service unless other arrangements have been made with our billing office. If measures to repay an outstanding balance have been made, payments *MUST be paid monthly and account current* in order to schedule appointments and be seen. I understand that if my account is not current I will not be able to schedule and be seen until my account is current.

As a service to our patients, we will file charges with your insurance company. The filing of insurance does ***NOT*** release the patient from responsibility for charges for services which have been provided. Please make sure we have a current copy of your insurance card. ***If we do not have the correct insurance information on the date of service and your claim is denied, you are responsible for payment.*** It is your responsibility to verify if our office is in network with your plan.

Accounts, which are not paid within a reasonable period of time, and for which no special arrangements have been made, will be subject to placement with collection agencies following due notice.

Having read and understood the above statements, I agree to the terms set forth:
(Please initial that you have read)

____1. I understand my co-pay or outstanding balance is due and payable at my appointment or I will need to reschedule my appointment.
_____2. I understand that I am financially responsible for all charges, even if they are not covered by insurance.
_____3. If my insurance does not pay, I understand that I am responsible for those charges.

_____4. In the event that I do not pay in accordance with the above policy and my account is sent to a collection agency, I agree to pay all costs of collection, including attorney fees.

—— 5. If my account is sent to collection, I understand I could be dismissed from this practice.
_____6. I understand that a 24 hour notice of cancelation is required. Should I fail to contact the office without 24 hours notice that you reserve the right to charge me a $25.00 late cancellation fee. Should I fail to call within 24 hours and no-show a fee of $50.00 will be charged to me.

Commercial Insurance, Medicare and Private Pay
Medicare and or your private insurance carrier will only pay for services that it determines to be 'reasonable and customary". Medicare will not cover any routine physical or routine lab work. Medicare will only cover one well woman exam every two years. It will be the patient's responsibility to verify that your insurance will cover any procedure that you are requesting or suggested by your provider. While we will do our best to verify coverage and being in-network, it is ultimately the patients' responsibility to confirm this with your insurance carrier.
Private and commercial insurances may deny coverage for the following reasons:

A. Classen Family Medicine, LLC, Dr. McCrory, PA. Smith**,** Dr. Hall, PA. Anto, PA. Johnston-Simpson is not listed as your PCP with your insurance. (HMO policies)
B. Patient is not listed as a covered dependent on said plan
C. Patient policy has/was terminated at time of service and/or patient did not present front desk with a current insurance card.
D. Patient went to a non-participating facility for any lab or tests, it is patient responsibility to verify correct lab and/or facility for tests
E. Insurance will only cover a limited amount toward a routine physical and/or labs
F. Routine physicals are only allowed every year or every other year depending on your insurance coverage
G. School, Sports and any other third-party physicals are not a covered benefit under any insurance plan

Patient, or guarantor/guardian hereby authorize the release of all applicable medical information including, without limitation, copies of all records and test results produced to the designated attending, referral and/or follow- up physicians and such other healthcare practitioners or organizations which will be providing subsequent monitoring, care or treatment in connection with care provided by Classen Family Medicine, LLC. I also authorize the release of information from my medical record in order to comply with applicable law, to facilitate the performance of utilization review and quality assurance activities and to facilitate third -party accreditation/certification activities. I accept responsibility for the medical charges incurred by the patient and agree to pay all bills at the time of service, unless other arrangements are made. I authorize physician and/or clinic to render medical treatment and to release information to process insurance claims and to determine Medicare benefits. I also authorize my insurance claim and/or authorized Medicare benefits to be paid directly to Classen Family Medicine, LLC. I further agree that a photocopy of this document is to be considered as valid as an original.

By signing this form, I have agreed to the terms and conditions listed above.

_____ _____
Signature of Patient/ Responsible Party *Date*

_____
Relationship to Patient