SKYVIEW
FAMILY MEDICINE

Office and Financial Policy

In an attempt to keep our patients informed and to ensure proper reimbursement for services rendered, we ask that you carefully review the following, ask any questions you may have, initial next to each section, and sign in the space provided. A copy can be provided at your request. Everyone's insurance coverage is different. Knowing your insurance benefits is your responsibility. Please contact your insurance company with questions you may have regarding your coverage. The phone number for this can be found on the back of all insurance cards.

Forms, Letters and Records: For complex or lengthy forms, there will be a $25 fee. Some forms may require an office visit to ensure that the information provided on the forms is correct. Forms that need to be completed within a 48 hour rushed time frame will incur a $35 charge for expedited completion.

Initial _____

Medication Refill Requests: We ask that you contact your pharmacy directly for all medication refill requests. Please allow 36 to 72 hours for a response on all refill requests. Please plan ahead so that you do not run out of your medication.

Initial _____

Prescription Monitoring Program: Our practitioners participate with the Prescription Monitoring Program. An inquiry will be run for any requests on controlled substances or for any prescription history to allow for proper medication treatment.

Initial _____

Referral: Please allow 5 business days for referrals to be completed.

Initial _____

Emergency Phone Calls: We ask that only **emergency** phone calls be placed to our "on-call" physicians' line. These calls go directly to our providers while they are home and away from the office. Those patients who call the physician with non-emergency complaints will incur a $25 fee.

Initial _____

Cancellations and No shows: Please try to give us 24 hour notice if you are not able to make your appointment. If you know it is short notice and you will not be able to make it, please still try to reach out to us or leave a voicemail so we can adjust the schedule. All missed appointments will be charged a $40.00 fee.

Initial _____

Insurance Coverage: We currently participate with most insurance plans including Medicare and Medicare supplement plans. You should always contact your insurance provider to confirm that we are participating with your plan. It is your responsibility to make sure you have updated insurance information at the time of the visit or you will owe payment in full for the visit. If you have an HMO insurance plan, please make sure to change us to the PCP before your appointment. We will file your insurance claims on your behalf with the information you have provided to us. **Knowing your insurance benefits, co-pays and deductibles is your responsibility. Problems relating to your coverage should be handled between you and your insurance provider. If you do not have insurance, please speak with our staff.**

Initial _____

Copayments, Coinsurance and Deductibles: ALL copayments and deductibles must be paid at the time of service. Balances may be collected at the time of service as well. We may have to bill the insurance to see what your responsibility is; it is your responsibility to pay this portion of your bill. We do have payment plans that can be set up if you are unable to pay the balance in full.

Initial _____

Non Covered Services: Please be aware that some of the services you receive may be considered non covered or not medically necessary by your health plan. You will be financially responsible for these charges.

Initial _____

Proof of Insurance: All patients are required to present a valid insurance card along with a copy of your driver's license or state issued photo id. If proof of insurance is not provided at the time of service, all claims will be billed to the existing insurance provider on file at the office. If you fail to provide us the correct insurance information at the time of service, you will be responsible for any balance of the claim.

Initial _____

Guarantor: The parent or guardian who signs the patient's paperwork is the party responsible for all charges and payments. If this person is to change, please inform us immediately so we can make changes to the account.

Initial _____

Claim Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly that we may not be able to. 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 company pays your claim. Failure to provide them with information to get the claim paid will result in the outstanding balance becoming your personal responsibility.

Initial _____

Nonpayment: All outstanding balances are to be paid upon receipt. Payment is required for past-due balances prior to your next visit. **After 3 statements, or if your account is 90 days overdue, your account will be sent to an outside collection agency for further collection efforts. You will be responsible for the outstanding account balance and all collection fees that are incurred from this agency.** If you are sent to collections, you and your immediate family members may be discharged from this practice. If this occurs, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, we will only be available to treat you on an emergency basis.

Initial _____

Returned Checks: If your payment is made by check and is retuned by the back for insufficient funds, you will be required to pay a fee of $35.

Initial _____

I have ready, fully understand, accept and agree to comply with all the above policies. I agree to comply with any future amendments to our policies. I consent to the assignment of authorized health insurance benefits by my health insurer to Skyview Family Medicine for any services furnished to myself or family member, and understand that failure to make payments in a timely manner may result in collection fees.

Patient Name(s) _____

Patient/Parent Signature _____ Date _____