"Where Your Healing Begins"

PAYMENT POLICY

Thank you for choosing Calvary Medical Clinic as your primary care provider. We are committed to providing our patients with the highest quality and most affordable health care in our area. 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 carefully, ask us any questions that you may have, and sign it in the space provided below. Upon your request, we will be happy to provide you with a copy of this payment policy.

✶INSURANCE:

We participate in most insurance plans, including Medicare. If you are not insured by a plan that we do business with &/or are a self pay patient, payment in full is required, before services are rendered, at each visit. If you are insured by a plan that we do business with but do not have an up-to-date insurance card and we are unable to verify your insurance coverage, payment will also be required, before services are rendered, at each visit until we can verify your insurance coverage. Please contact your insurance company with any questions that you may have regarding your insurance coverage because knowledge of your insurance benefits and knowing who your primary care provider is, is your responsibility.

✶CO-PAYMENTS AND DEDUCTIBLES:

All co-payments and deductibles are required, before services are rendered, at each office visit. This arrangement is part of your contract with your insurance company and failure on our part in collecting co-payments and deductibles from our patients can be considered fraud. Please help us in upholding the law by paying your co-payments and deductibles at each visit.

✶NON-COVERED SERVICES:

Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered reasonable and necessary by Medicare or other insurances. You must pay for these services, in full, at the time they are rendered.

✶PROOF OF INSURANCE:

All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current and valid insurance in order to provide proof of your insurance coverage. If you fail to provide us, in a timely manner, with the correct insurance information you will be responsible for the balance of your insurance claim(s).

✶CLAIMS SUBMISSION:

We will submit your insurance claim(s) and assist you in any way we reasonably can to help you get your insurance claim(s) paid. Your insurance company may need you to supply certain information directly and it is your responsibility to comply with their request. Please be aware that, even though our prices are representative of the usual and customary charges for our area, the balance of your claim(s) is your responsibility whether or not your insurance company pays for your claim(s). Your insurance benefits are a contract between you and your insurance company & we are not a party to that contract.

✶COVERAGE CHANGES:

If your insurance changes, please notify us before your next visit so that we can make the appropriate changes to help you receive your maximum insurance benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.

✶NONPAYMENT:

If your account is over 90 days past due, you will receive a letter stating that you have 20 days to contact us regarding payment on your account. Partial payments will be accepted upon authorization. Please be aware that if a balance remains unpaid, we may refer your account to collection and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 days, our physician will only be able to treat you on an emergency basis.

I have read the payment policy, asked questions &/or expressed my concerns, and now understand and agree to abide by its guidelines.

Date: ______/______/______
Patient / Responsible Party Name*(printed)*:____
Patient / Responsible Party Signature:____