

PALMETTO FAMILY MEDICINE
109 Barton Creek Court Columbia, SC 29229
803.256.2286 extensions 305/307

FINANCIAL POLICY

We know that choosing a physician is a very important decision and we thank you for choosing Palmetto Family Medicine. Carefully read this overview of some of our financial policies.

INSURANCE CARDS: You will be asked to provide your insurance card (s) at every visit.

This is to confirm that the information we have is correct, that your plan is current, and one in which we participate. Out of date cards with incorrect information or the wrong insurance cards can cause unnecessary delays in the payment of your claim.

Frequently, small changes (for example, a group number change or plan change) may not be considered significant by the patients, but the insurers will not process claims that are not 100% accurate.

CO-PAY: All office co-pays are to be collected at the time of service. This is an insurance company policy. If the co-pay is not paid at the time of service, you will be assessed a \$25.00 late fee. We accept checks, credit cards, and cash.

COVERAGE: The agreement of the insurance company to pay for medical care is between you and the carrier. We will submit insurance claims for our patients. However, you should direct any questions and/ or complaints regarding coverage to your insurance carrier, your employer (if in a group plan), or to your agent.

Insurances vary in their coverage, and it is the patient's responsibility to understand his/ her medical benefits. There may be limitations and exclusions to coverage. The patient portion is set by the insurance company. Patients are responsible for any co- insurances, deductibles, and any other non-covered billable services. In the event your health plan determines a service to be "not covered" or you provided incorrect or late insurance information, you will be responsible for the complete charge unless other arrangements are made. If this occurs, we will bill you and a payment is due upon receipt of that statement.

We do not bill third parties. It is the responsibility of the patient to satisfy any outstanding balances here. We will provide statements as proof of payment for patients to pursue reimbursement from the third party payer. Your balance is your responsibility.

WELLNESS BENEFITS: On the day of your appointment, advise the staff if you have Wellness Benefits. It is your responsibility to let PFM know that you have WELLNESS BENEFITS the day of the appointment. Without this information from you, the patient, Palmetto Family Medicine is unable to file the claim correctly for you to receive your benefits. Once the charges have been sent to the insurance company, PFM will not be able to change or add any diagnosis codes to re-file the claim.

SELF -PAY PATIENTS: \$75.00 will be collected before the patient sees a physician/ physician's assistant on the day of service. The \$75.00 will be credited to the patient's total bill. On the day of service after seeing a physician/ physician's assistant, if the payment is made in full at the time of the visit, a 35% discount will be applied to any balance greater than \$75.00. After the day of service, no discount is offered if the remaining balance was not paid in full on the date of service. The patient will be mailed a statement for charges incurred on that day.

OVERDUE PAYMENTS: Payment is “overdue” when a balance exceeds 30 days from the date of service unless other arrangements have been made. If your account is sent to collection agency, you will be responsible for the collection agency’s fees as well. If your account is sent to the collection agency, you may also be discharged from the practice.

FINANCIAL HARDSHIP: If you find yourself in financial hardship, contact the billing office (extensions 305/307) to coordinate a payment plan. Alert PFM and make a plan for payment so that you will not be sent to collections and discharged for non-payment.

MISSED APPOINTMENTS: \$25.00* charge is assessed for office appointments not cancelled 24 hours in advance. Please call us as early as possible if you know that you will need to reschedule your appointment.

*SLEEP STUDY (Cancel 48 hours in advance to avoid a \$250.00 fee.)

*CPET/MET TEST (Cancel 48 hours in advance to avoid a \$175.00 fee.)

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I understand that I am financially responsible for all charges whether or not they are covered by insurance and agree that such terms may be amended from time to time by the practice.

Printed Name

Signature

Date

***The patient has the responsibility of notifying PFM if the patient has a change of insurance provider, change of patient address &/of change of patient phone number(s).

Communication with the billing office concerning any charges, your bill, overdue payments, or financial hardship is extremely important. Do not hesitate to call to discuss any of these issues.