IVY FALLS FAMILY MEDICINE
Patrick J Voswinkel, MD, FAAFP

OFFICE PAYMENT POLICY
Effective September 1st, 2007

Given the constant changes to insurance company payment policies, the following in-office policies have been established to help us continue to provide the patient with the best quality of medical care. These policies are not meant to offend or insult anyone, but only to serve as a guideline for greater understanding in all aspects of patient care. If you would like to discuss the office fee schedule, or these office policies please ask the Doctor or Office Manager.

PAYMENT IS DUE AT THE TIME OF SERVICE. This includes Co-pays, Deductibles, percentages due, and non-covered charges. Other arrangements will be considered only when requested **PRIOR** to services being rendered.

a) Co-pay must be paid at the time of visit. Co pays not paid at time of the office visit will incur an additional $5.00 charge.

b) For the patient's convenience, the office accepts cash, check or Visa & Master Card

c) The patient is responsible for all NON-COVERED SERVICE CHARGES.

d) A $30.00 processing fee will be charged for all returned checks. Efforts are made to eliminate this by using our check processing system (converting your check to an automatic debit from your account)

ANY CHANGES to your DEMOGRAPHICS or INSURANCE must be brought to our attention, **BEFORE** the Doctor's visit. Failure to do so may result in the patient being **responsible in FULL for ANY & ALL charges** for services rendered. The **CORRECT** information is **CRITICAL** especially for proper billing of laboratory test that may be required and ordered. If this information is incorrect or not current the patient will be responsible for the bill in its entirety.

Medicare cards MUST be Valid and UP-TO-DATE. We DO NOT participate with MEDICAID, if you are a MEDICAID participant and elect to be seen by our office you are responsible for payment, or any balance after your primary plan has paid.
HMO, PPO, POS or other Health Plan ID cards must be current, have Dr Voswinkel's name and correct office phone number (if required by the plan).

If you have medical insurance, as a courtesy to you we will try to speed up the processing of your claim by electronically submitting to your insurance company. However, your insurance is a contract between you and your insurance company. Our office **CANNOT** guarantee that your carrier will pay your claim. If your claim is denied by your carrier, the obligation for payment is the responsibility of the patient. Our office will not enter into a dispute with the insurance carrier over the claim. We will however, be happy to assist wherever possible.
Outstanding payment due for over 30 days may incur Interest Charges of 1.5% for every 30 days that the payment remains overdue (to an annual Interest rate allowable by law to 18%). Billing statements will be mailed every 4 weeks.
If the patients' bill remains overdue greater than 60 days the following procedure will occur:

Interest charges will continue to accrue.
Postage and office charges of $10.00 will be added to the bill per billing cycle.
The account will be turned over to a third Party for collections and a collection fee of $25.00 plus any additional cost for collections will be added to the account.
All outstanding bills must be settled prior to receiving future care, unless **PRIOR** arrangements have been made.

Cancellations/Missed appointments - Failure to keep your appointment or failure to cancel your appointment without reasonable time to fill the time slot we have reserved for you will result in a penalty charge of $40.00, except in the case of a missed Physical Exam or Comprehensive Medical Exam the charge will be $50.00.
This fee is **NOT** covered by insurance and is the sole responsibility of the patient. You the patient will be billed accordingly. *Please have the courtesy and respect to call our office for all appointments that can not be kept. We work with you at every opportunity to provide you with the best quality health care.*
I have read and understand the payment policy and agree to abide by its guidelines:

Print Name_____
Signature ***Date***