



## PATIENT FINANCIAL POLICY

Thank you for choosing Pine Top Medical as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is part of that relationship.

### **PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW**

Please present your insurance card(s) at each visit. It is your responsibility to notify our office of any change in patient information (i.e. name, address, insurance information, etc.). You are responsible for payment on any balances remaining or denied claims. .

**Co-pays:** We will collect your deductible, co-payment, or payment for non-covered services, along with any patient balance due the time of your visit. All co-payments and past due balances are due at the time of check-in unless previous arrangements have been made with Pine Top Medical. We accept cash, checks, Visa, Master Card and Discover.

**Insurance Claims:** Insurance is a contract between you and your insurance company. In most cases, we will bill your primary insurance company as a courtesy to you. You are required to disclose all insurance information, including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete and accurate information may result in patient responsibility for the entire bill. You agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately. If we do not receive payment from your insurance within 45 days, you will be billed for any unpaid balance, which will incur interest at the rate of 1.5% from the date of service.

**Past Due Balances:** All balances are to be paid in full within 30 days. If payment on your account is not done in a timely manner, your account may be referred to a collection agency and reported to the credit bureau. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collection costs, including attorneys' fees and court costs. Pine Top Medical may record a Lien to perfect its right to recover past due balances.

**Medicare Patients:** We will submit to Medicare for all your covered services. If you have a supplemental insurance, we will also submit that for you as a courtesy. If payment is not received from your supplemental insurance within 30 days of being submitted, we will invoice you for the balance due. If you do not have a supplemental insurance, your portion (20% of amount allowed by Medicare) will be collected at the time of service. Each year you will be expected to pay the allowed amount of your charges until your Medicare deductible is met.

**Medicaid Patients:** We are a participating provider with Medicaid. We will submit to Medicaid for your covered services. Any unpaid portion is your responsibility.

**HMO-PPO Patients:** If we participate with your plan, we will submit your services to your insurance for you. Your co-payment will be collected at the time of service-no exceptions. If your plan requires you to choose a primary care physician, it is your responsibility to make sure your insurance company has the physician you are seeing in our office as your PCP. If your plan requires you to have an authorization to



To see a specialist, you will need to obtain that from our office prior to seeing the specialist. 72 hours notice is required to obtain all referrals. We cannot obtain retroactive referrals. If we do not participate with your plan, we will verify your out-of-network benefits, file your services, and we expect payment of your portion of the services at the time of your visit.

**Workers' Compensation:** It is the patient's responsibility to provide our office with employer authorization and/or contact information regarding a workers' compensation claim. If the claim is denied by the workers' compensation insurance carrier, it then, becomes the patient's responsibility. At your request, we will submit the claim to your primary medical insurance carrier with a copy of the workers' compensation insurance denial. If your claim is denied by your primary medical insurance carrier, you will be responsible for payment in full.

**Self-Pay Patients:** Patients without insurance coverage will be expected to pay at the time of service. If you will not be able to pay in full, you must contact our office manager prior to seeing the doctor to make payment arrangements.

**Minors:** The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release may be required for unaccompanied minors.

**No Show Or Missed Appointments:** We understand there may be times when you are unable to keep an appointment. 24 hours notice must be provided to prevent incurring a cancellation fee. If an appointment is missed without proper notice you may be charged a \$50.00 fee. Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of your services. If you have any questions regarding our financial policy, please contact our office manager.

**Medical Records Requests:** Patients, their agents, representatives or legal counsel requesting copies of medical records will be charged a reasonable fee for copying and staff time.

Pine Top Medical reserves the right to terminate the Physician-Patient relationship for failure to pay balances past due, in accordance with our Patient's Rights and Responsibilities. Please direct all financial and/or billing questions to our staff.

**I have read and understand the Patient Financial Policy and agree to be bound by it.**

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Signature (Patient or Responsible Party)

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Date

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Printed Name



## Pine Top Medical Office Policy

### Prescription refills

Timely management of your prescription medication needs is very important to us. Your participation in managing your medication needs is appreciated. By following these guidelines, it will help ensure your medication are efficiently maintained.

- Please have your prescriptions refilled during business hours, not on the weekends or holidays. This is best accomplished during your scheduled physician visit.
- **Call your pharmacy first:** they will notify our office of your medication needs.
- Please call for refills at least four days prior to running out of your medication.
- When calling for a refill, allow up to 48 hours for the physician to review your request and call your pharmacy.
- In-complete or missing information may result in a delay in prescription authorization. It is always best to have your pharmacy contact us.

### Return phone calls

Managing your medical concerns on days when you are not scheduled for a provider visit is also very important to us. Please keep in mind that your physician sees a variety of patients. Please be aware that the physician or nurse may not call you back until after clinic hours, depending on the urgency of your request. Urgent or emergency problems will be addressed within two hours. When calling for lab results, allow 48 hours for the physician to review your results and nurse to return your call. If you have an emergency that requires immediate attention, please go directly to the nearest emergency department or dial 911.

Please remember this facility **does not** prescribe chronic narcotics.

### Late arrival policy

Please try to be on time for your scheduled appointment. If you are more than 15 minutes late, you may be asked to reschedule your appointment. If you find it impossible to be on time, please contact our office. If you are unable to make your appointment and need to reschedule a 24 hour notice is required. If your appointment is missed without proper notice you may be charged a \$50.00 fee.

### Paperwork

Any paperwork IE: FMLA, disability paper work, handy cap paperwork may be charged a \$25.00 fee. That needs to be rendered before paperwork will be completed.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## HIPAA Form

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996, a federal law. Administrative Simplification section of this Act is of Concern to our practice and requires us to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals and employers
- Healthcare Transactions & CodeSets for transmitting electronic data
- Privacy Regulations over disclosure and use of health information
- Security Regulations over protections of electronic health information

All of these rules have been developed by the Department of Health & Human Services. It will be the policy of Pine Top Medical to release confidential information with signed consent by home telephone, answering machine, work telephone, voicemail and cellular phones.

Whenever returning telephone calls and the answering machine picks up, it is our policy NOT to leave confidential information if there is no recorded message identifying the residence. Confidential information will NOT be left with an unauthorized person who may answer your telephone.

If you would like to have your medial information released to someone other than yourself, please complete the following:

I authorize Pine Top Medical to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

Home Telephone      Yes No

Answering Machine      Yes No

Work Telephone      Yes No

Voice Mail      Yes No

Cellular Phone

Please List authorized persons:

Spouse/Fiancé: \_\_\_\_\_

Phone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Phone: \_\_\_\_\_

Brother/Sister: \_\_\_\_\_

Phone: \_\_\_\_\_

Friend/Other: \_\_\_\_\_

Phone: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Last Name:		First Name:		M.I.		Previous Name:	
Mailing Address:				Apt#:			
City/ State/ Zip:							
Home Phone:		Cell Phone:		Work Phone:			
Preferred method of contact for reminder calls & other electronically generated messages:						(Please select only one)	
						Voice    Text	
						If voice, select preferred number	
						Home    Cell    Work	
Family Physician:				Date of Birth:		Sex:	
						Male    Female	
Marital Status:			Social Security #:		Employer Name:		
Emergency Contact Phone#:				Relationship to Patient			
<b>Responsible Person</b>							
Last Name:				First Name:			
Date Of Birth:		Social Security #:		Phone:			
Address of Person Responsible:							
City/State/Zip				Relationship to Patient:			
<b>Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW)</b>							
Email Address:				Can we leave a message regarding your medical care & test results?			
				Yes    No			
Race:				Ethnicity:			
White    American Indian or Alaska Native    Asian    Hispanic    Black or African American				Hispanic or Latino			
Native Hawaiian or Pacific Islander    Other    Decline				Not Hispanic or Latino    Decline			
Preferred Language:							
English    Bosnian    Indian(Including Hindi & Tamil)							
Sign Language    Spanish    Russian    Other							
<b>Primary Medical insurance</b>				<b>Secondary Medical Insurance</b>			
Ins. Co Name:				Policy Holder Name:			
Policy Holder Name:				PolicyHolder Name:			
Policy Holder's Date of Birth:				Policy Holder's Date of Birth:			
Policy Holder's Social Security#:				Policy Holder's Social Security#:			
Patient Relationship to Policy Holder:				Patient Relationship to Policy Holder			
<p>I have read and agree to Pine Top Medical of payment policy. I understand that payment is my responsibility regardless of insurance coverage. I hereby sign to Pine Top Medical all money to which I am entitled for medical expenses related to the services performed from time to time by Pine Top Medical, but not to exceed my indebtedness to Pine Top Medical. I authorize Pine Top Medical to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A \$25.00 returned check fee will be charged for checks returned due to insufficient funds. By choosing text messaging and/or email as a communication method, I acknowledge that Pine Top Medical is not liable for any wireless charges I may incur and that unencrypted patient information may be sent to me via text message or email.</p> <p>MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to Pine Top Medical, I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.</p>							

I have reviewed a copy of Primary Health Medical Group's Privacy Notice.  Initials

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_