



Choices in Health, PC

4790 Table Mesa Drive, Ste. 202
Boulder, CO 80305

Our Patient Payment Policy

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

All patients must complete our Patient Information Form. We believe that a good relationship is based on understanding and open communications. Our staff has been instructed to make every effort available to you to clarify any misunderstanding you have concerning your balance.

For your convenience, we have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies, please ask to speak with our Billing Specialist or the Practice Manager.

How May I Pay?

We accept payment by cash, check, VISA, MasterCard and Discover. For your convenience, our billing office is staffed Monday through Friday from 8:00 AM to 4:30 PM. The phone number is 877-320-1692.

You are expected to make payment in full upon receipt of a billing showing your balance due or according to the terms below:

Balance Due

\$1-10,000

Terms

Payment in full within 30 days

Other payment plans or options may be available upon completion of a financial statement analysis. Please contact our Patient Financial Services for this information. A monthly billing charge will be added to all accounts not paid in full within 45 days of service.

When is my account delinquent?

An account is considered past due 30 days following billing unless other arrangements have been made. Unpaid accounts beyond 120 days are considered delinquent and may be forwarded to our collection agency and will be charged an \$11.50 service/billing fee.

How are my Medicine Refills handled?

Our policy is for the patient to call their pharmacy and ask them to **fax** the request for your medication to 303-444-0840. Requests are usually handled within 48 business hours. Processing times may vary depending on the availability of your doctor, who for your safety must review each request prior to completion.

Are there Service Charges?

If the decision is made to see a patient, who does not have his/her co-pay or deductible a service charge of \$5 will be added.

There will be a billing fee of \$10.00 added to each statement billed after 75 days of service.

Copying of Chart

There will be a service/copying fee of \$5 - \$50 added to each chart. Determination of cost depends on size of chart.

Phone Calls to Doctors

Our physicians will not be doing telephone Medicine; if you need to talk your doctor we will give you an appointment. Calling the doctors after hours will result in a charge which insurances do not pay-making you responsible.

Do I Need A Referral?

If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, we have a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral, YOU will be rescheduled.

Your referring physician has received a request for important patient information what will have to be received before surgery can be scheduled. (If

you see a specialist, especially cardiology, you may need to have information forwarded to this office to expedite your care.)

What Is My Financial Responsibility for Services?

Your financial responsibility depends on a variety of factors, explained on page 4. Claims that have not been paid in 45 days will be automatically billed to you and we can assist you in refilling your insurance at your request.

What about missed appointments?

We would appreciate your help and courtesy of a call if you are unable to keep an appointment. Please notify our office at least twenty-four (24) hours prior to the appointment time. We reserve the right to charge you a missed appointment fee of \$50 and three (3) non cancelled missed appointments are grounds for patient discharge.

Legal Fee:

Any patient sent to collections will be responsible for all collection fees. If a patient is taken to small claims court the patient will be responsible for all fees/charges.

Emergencies after hours

If you need medical care when the office is closed, please go to the ER. You will be escorted to the doctor's Payment Coordinator. She will answer specific questions about the process, discuss the paperwork and tests involved, and complete all pre-certification/authorization if your insurance company requires it.

The Coordinator will request a deposit, the amount of which depends on your coverage and deductible amount. A cost estimate which shows your financial responsibility, based on the benefit levels and coverage of your insurance plan, will be explained by the Coordinator.

What if My Child Needs to See the Physician?

A parent or legal guardian must accompany patients who are minors on the patient's first visit. This accompanying adult (who consents to the treatment) is responsible for payment of the account, according to the policy outlined on the previous pages. We will not be involved in separation/divorce disputes.

If You Have.....	You Are Responsible For.....
Commercial Insurance Also known as indemnity, “regular” insurance, or “80%/20% coverage.”	Payment of the patient responsibility for all office visit, x-ray, injection, and other charges at the time of office visit.
HMO & PPO plans with which we have a contract.	<p>If the services <u>you</u> receive are covered <u>by</u> the <u>plan</u>: All applicable co-pays and deductibles are requested at the time of the office visit.</p> <p>If the services <u>you</u> receive are not covered <u>by</u> the <u>plan</u>: Payment in full is requested at the time of the visit.</p>
HMO with which we are <u>not</u> contracted.	Payment in full for office visits, x-ray, injections, and other charges at the time of office visit.
Point of Service Plan or Out of Network PPO	Payment of the patient responsibility-deductible, co-pay, non-covered services-at the time of the visit
Medicare	<p>If you have Regular Medicare, and have not met your \$110 deductible, we ask that it be paid at the time of service.</p> <p>Any services not covered by Medicare are requested at the time of the visit.</p> <p>If <u>you</u> have <u>regular</u> Medicare as <u>primary</u> and also have <u>secondary</u> insurance or <u>Medigap</u>: No payment is necessary at the time of the visit.</p> <p>If <u>you</u> have <u>regular</u> Medicare as <u>primary</u>, but no secondary insurance: Payment of your 20% co-pay is requested at the time of the visit.</p>
Medicare HMO	All applicable co-pays and deductibles are due at the time of the office visit.
Worker’s Compensation	<p>If we have verified the claim with your carrier, no payment is necessary at the time of the visit.</p> <p>If we are not able to verify your claim, Payment in full is requested at the time of the visit.</p>
Worker’s Compensation (Out of State)	Payment in full is requested at the time of the visit.
No Insurance	Payment in full is requested at the time of the visit.

You will be escorted to the doctor's Payment Coordinator. She will answer specific questions about the process, discuss the paperwork and tests involved, and complete all pre-certification/authorization if your insurance company requires it.

The Coordinator will request a deposit, the amount of which depends on your coverage and deductible amount. A cost estimate which shows your financial responsibility, based on the benefit levels and coverage of your insurance plan, will be explained by the Coordinator.

Assignment of Benefits

You need to assign benefits/payments for your insurance payments to the doctor.

What is an ABN?

An ABN is a form that lets you know that you may have to pay for a service/test your doctor has ordered if your insurance refuses to pay for it. If you sign the ABN, the doctor's office may bill you for the cost of the ancillary service/test.

Why do you want me to sign the ABN?

Although insurance programs pay for most services/tests, it won't pay for some under certain circumstances. If that happens, the doctor's office must ask the patient to pay. Consequently, patients are asked to sign an ABN whenever insurance appears likely to deny payment for the ancillary service/test the doctor has ordered.

If Insurance says the service/test isn't medically necessary, then why perform it?

Your doctor has made a medical judgment that you need the service/test. When your doctor says a service/test is medically necessary, he/she considers your personal medical history, any medications you may be taking, and generally accepted medical practices. When insurance says a service/test isn't medically necessary, it's not making a medical decision about your health. It's acting like an insurance company deciding what it will pay.



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Our Patient Payment Policy Consent Form

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to Choices in Health, PC.

I authorize Choices in Health, PC to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Date: _____

Printed Name: _____

Signature: _____