



of Indiana, LLC (type in appropriate Practice address & phone number in this space)

Patient Financial Policies

Insurance Billing

We are your healthcare provider and as a courtesy to you we will file your claims to your insurance company. However, it is your responsibility to understand what services are covered under your medical insurance policy. If you have any questions whether a service is covered we urge you to contact your insurance company, before the service is provided.

The fees and codes for the services that are provided to you are based on the guidelines of the American Medical Association. There are several factors involved when making the decision for the level of services to be billed. Among those deciding factors is whether you are a new patient (not seen within the last three years) or established patient, the reason for the visit, the amount of time the service takes, the complexity of the medical problem, and whether any additional testing is done.

Insurance companies make their payment decision on a specific medical service by looking at what your insurance policy provides. **Example:** If the reason for your visit is a sports physical and your insurance company does not cover that service we cannot go back and change the reason for your visit. It is your responsibility to find this out ahead of time.

Many times routine services such as office visits, laboratory services, mammograms, screenings, and annual physicals are not covered under insurance plans. We suggest you contact your insurance company to find out what benefits you have under your policy, before services are rendered by us. The customer service number is usually found on your insurance card.

Be advised that your insurance company may require a pre-certification, prior authorization, or referral for extended services such as; radiology, surgery, specialists, and/or services provided at places other than in our facility. Patients should take responsibility to ensure these have been obtained prior to services rendered.

Billing Information: It is essential that you provide us with complete and accurate information. We make every effort to submit your claims to your insurance company and promptly provide you our statements. However, if for any reason your statement is returned to our office because of a problem with an address you provided we will make only one final attempt to contact you, by the telephone number you provided. After this attempt your account may be sent to collections. To avoid this please keep your information up to date.

Please be sure to have your insurance cards with you at every visit so that we may properly bill your insurance carrier. If you do not have your card with you, you will be required to make payment in full that day.

Please note: **If you are injured in an accident and believe that someone other than your medical insurance company is responsible for payment -** If you provide us with adequate information at the time your services are rendered, we will attempt to bill that party for you. You must work with that third party to secure reimbursement on your behalf. If we are not paid within XX days of the services rendered you will be billed consistent with these policies (which means you will be responsible for the payment).

Workers Compensation Injury? If you believe you are being seen for an injury/illness as a result of your job, we will need a document from your employer to confirm this and their directions as to how to bill for this service. If we do not have this information we will bill you/your insurance carrier.

Other Fees

(1) **Returned Check Fee:** \$XX (2) **Completion of Forms** (Disability or Family Medical Leave): \$XX
(3) Failure to cancel appointment fee ("**No Show**") - if you do not advise us of your inability to make your appointment within XX hours prior to your appointment - we will assess you \$XX since another patient was not able to be seen in that time period. (4) **Prescription Refills** - There may be a charge (of \$XX) to refill a prescription if significant time is needed to review your medical record. (5) After Hour Calls - There may be a charge (of \$XX) if you need to contact us after business hours (and its not an emergency?)

Responsibility for payment: Our relationship is with you, our patient, to provide quality healthcare. Consequently, all charges incurred are your responsibility. The obligation to ensure payment in a timely manner lies with you. Unfortunately, we cannot always depend on your insurance company to make timely payment on your behalf. Delays, misplaced claims, or the need for additional information from the insurance company is not uncommon.

You should normally receive a response from your insurance company within 30 days. This is in the form of an "**Explanation of Benefits**" (or "**EOB**"). If you do not, we would appreciate you contacting your insurance company to check the status of your claim in order to expedite payment. Please call our billing department at (xxx) xxx-xxxx, if you encounter any difficulty with your insurance company. We will be happy to assist you. You will be responsible for payment until the account is paid in full by your insurance carrier.

Payment terms: Depending on your insurance policy benefits, you may be responsible for a co-payment, co-insurance, deductible, or for the entire services rendered. We require payment for these at the time of your office visit. If you fail to make payment at the time of service we will add a \$10 processing fee to cover our extra expense of preparing and sending out a bill.

Once we have received an Explanation of Benefits from your insurance company, which indicates the amount you will be responsible for, a statement for the balance will be sent to you and payment is expected by the Due Date. The "Due Date" is within 30 days of that statement's date. For example if the statement's date is December 1, then the Due Date is December 31. If you fail to pay the balance indicated by the Due Date an interest charge will be added to your account.

The **INTEREST** we charge is 18% per year, or 1 & 1/2% per month. **For example** if you don't pay \$100 dollars by the Due Date of Sept. 1st, then your next statement will include the added interest of 1 1/2 percent, meaning \$101.50 will be due on Oct. 1st. If you pay all but \$50 then on Nov. 1st you will owe \$50.75.

Note to divorced parents of dependents. Unless you provide us with a court order, we presume both parents are responsible for the dependent's fees. We will send our statement to the address we have where the child resides, and parents can sort out who should pay without AHN involvement.

Self-Pay Patients

Self Pay Patients are those not covered by any insurance policy or third party payer. Self Pay Patients will receive a 15% discount across the board for all services rendered, **when payment is made in full at the time services are rendered** (and where no claim form is prepared or billing statement has to be mailed).

AHN Patient Financial Policies, Con't

Payment Options:

If you are unable to meet your financial obligation, payment arrangements can be made. You must contact our billing department at (xxx) xxx-xxxx to discuss your payment options, **before your account becomes over due.**

We also accept Visa, MasterCard, and Discover.
Please call (xxx) xxx-xxxx to make credit card payment by phone.

Acknowledgement of American Health Network Financial Policies

Patient Name: _____ Date of Birth: ___/___/___

I acknowledge I was given a copy of American Health Network's Patient Financial Policies and that I have read and understand them and had the opportunity to ask questions. I agree to abide by these terms.

Signature _____ DATE _____

MAKING PAYMENTS: Patients may pay by cash, money order, check or personal credit card. **In addition,** you might have a credit card to pay from your "flexible spending account." **And** in some cases your insurance policy may consist of a "health savings account" which can be accessed through a credit card. One, or all, of these cards may be used.

Credit Card Payments

I agree that if American Health Network receives the Explanation Of Benefits (EOB) for my services, which shows that I have an outstanding balance, I authorize AHN to charge this amount to my credit card(s) listed below. I understand that I retain the right to contest such charges.

Personal Account Information

Account Carrier _____ Number _____ Expiration Date _____

Authorized Signature _____ Date: _____

Flexible Spending Account Information

Account Carrier _____ Number _____ Expiration Date _____

Authorized Signature _____ Date: _____

Health Savings Account Information

Account Carrier _____ Number _____ Expiration Date _____

Authorized Signature _____ Date: _____

NOTE: Practice should keep this page and make a copy for the patient