Compassion Care Clinic PLLC

Our Financial Policy

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Compassion Care Clinic, medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Insurance

We participate in most insurance plans, including Medicare and Tennessee Medicaid. ***If you are not insured, we accept cash payments paid in fill/ at each visit***. If we do accept your plan, but you do not have a current insurance card, your appointment must be rescheduled. ***Knowing your insurance benefit plan is your responsibility***. It is your responsibility to make sure the correct in-network facility is used for all office visits, tests, and hospital encounters. Please contact your insurance company with any questions you may have regarding your coverage.

A Coordination of Benefits form (COB) must be filled out annually and sent to your insurance company to let them know whether you have additional coverage. Failure to return this information to your insurance company will result in denial of payment on claims, and all charges will be your responsibility. We CANNOT update this information for you.

Authorization to Release Information

I hereby authorize Compassion Care Clinic to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature

Coverage Changes

If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. This includes updating your COB with all your insurance carriers.

Co-payments

All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure to pay co-payments and deductibles is considered a breach of your insurance contract. Please help us by being aware when a copay is required and paying your co-payment at each visit as necessary.

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Co-insurance and Deductibles

Payment is due at the time of service. We file your insurance as a courtesy to you, our patient. If you have a commercial plan with a deductible amount for the year that you have not met, you will be asked to pay $50.00 prior to your appointment. This amount will include any copay due, and the rest will go toward the deductible or coinsurance that will be left to you by the insurance company.

Your co-insurance and/or deductible balance is your responsibility once your insurance has processed the claim. Regarding any disagreements you have with this amount, *you must take them up with the insurance company*, because this is part of your contract with them. Please note that you CANNOT carry co-insurances and deductibles over month to month unless you have made prior payment arrangements with our billing department.

Payment

We accept payments by cash, check, VISA, MasterCard, Discover, or American Express. If a check is returned for insufficient funds or payment has been stopped, you will be charged a fee (up to $42) in addition to the amount of the check. If you have a check returned, you will be asked to pay by cash, money order, cashier's check, or credit card for future visits.

You must pay all previous balances at the time of service, unless you have made prior arrangements with our billing department. You will be asked to pay a percentage of a due balance upon arrival for an appointment at our office. We reserve the right to ask for payment upon receiving a remittance advice from your insurance company. Statements are mailed out monthly; however, you may request a copy at any time from our office.

Nonpayment

If your account becomes delinquent, you must pay any charges on your unpaid bills, including, but not limited to, a 35% collection agency fee. Your account is considered past due if we have not received payment after you have received two statements. At that time, you will receive a letter stating that you have 15 days to either pay your account in full or contact our billing office to set up a payment plan. Payment plans may not exceed a 6-month period without special approval. You must contact us for a reasonable payment arrangement or risk collection action. Please be aware that if the balance remains unpaid, we may refer your account to a collection agency and/or proceed with legal action as necessary. Once your account has been sent to a collection agency, our practice will be unable to see you until the balance is paid in full.

Bankruptcy

Patients who declare bankruptcy may be temporarily dismissed from the practice until the bankruptcy is resolved. When patient demonstrates ability to pay, we shall reinstate the patient with a deposit on outstanding expenses.

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Private Pay

A minimum $70 payment for existing patients and $120 for new patients is due prior to treatment from all uninsured patients, unless patient is qualified for facility low income sliding fee. The initial payment is to see a provider, not to include any additional services provided. Thus, any additional procedures will result in additional charges and will be your responsibility. You must pay any additional balances prior to leaving the office.

Minor Patients

All patients 17 years old or younger must have a guarantor over the age of 18.

Proof of Insurance

All patients must complete our patient information form periodically prior to seeing the doctor. ***We must have a copy of your driver's license or valid photo ID, your current insurance card and your social security number to confirm proof of insurance and me your claim***. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims Submission

We Will submit your claims and assist you in any way we reasonably can to get your claims paid. ***In order to submit claims, we must have the patient's date of birth, social security number and a copy of your photo identification as well as a copy of the insurance card(s). In addition, we must obtain the policyholders date of birth and social security number to me claims with your insurance carrier***. We will file supplemental insurances when appropriate. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility, whether your insurance company pays your claim or not. Your insurance benefit is a contract between you and your insurance company—we are not party to that contract.

Print name: _____

Signature: _____ Date: _____