Patient and Financial Policy Information

Thank you for choosing us as your health care provider. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

SELF PAY/NON-PAR INSURANCES: The patient is responsible for payment for these services when they are rendered. We do accept Visa and Mastercard. If we do not participate with your insurance, a statement containing all the necessary information to bill your insurance will be given to you. You will simply attach the statement to your own claim form for reimbursement.

WE DO PARTICIPATE WITH THE FOLLOWING INSURANCE CARRIERS:
All non covered services and copayment's for the carriers listed below are due at time of service.

Traditional Medicare plans and CHAMPUS/Tricare (Humana Military).
The Medicare Advantage plans we participate with are AETNA, Advantra/Coventry Health, Amerihealth/Caritas NE, Humana Medicare Advantage, United Healthcare, UPMC Medicare Advantage and Highmark Medicare Advantage.

PA Blue Shield plans including Premier Blue, IBC & Federal BS.
Highmark
Coventry/HealthAmerica/Advantra
Cigna
United Healthcare
UPMC

Medicaid Products:
PA Traditional Medical Assistance, Amerihealth/Caritas NE and UPMC.

Vibra Health (a Capital Blue Cross Medicare Advantage Plan as of 1/1/2019

COLLECTION OR OPEN BALANCES: If you have a balance in collection or an open balance for previous services, the office may use their discretion as to seeing you again. It may be required that you pay your previous balance prior to being seen. If you are seen, you will be responsible for any services that were performed on that day. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 60-90 days, the balance will be your own personal responsibility.

DISABILITY FORM PREPARATION: This office charges a fee for all form completion. The fee is dependent on the type of form. If you have disability forms that need to be prepared by our office, we will try to do them as quickly as possible. However, they may take several days to complete.

PATIENT PHYSICIAN AGREEMENT STATEMENT: I understand that I am entering into a contractual relationship with Practice Name for professional care. I further understand that merit less and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Practice Name , I and/or my representative agree not to advance directly or indirectly any false, merit less and/or frivolous claim(s) of medical malpractice against any provider at Practice Name .

Furthermore, should a meritorious medical malpractice case of cause of action be initiated or pursued, I and/or my representative agree to use an American Board of Medical Specialty board certified expert medical witness in the same or similar specialty as my physician. Furthermore, I agree that these expert witnesses will adhere to the guidelines and/or code of conduct defined by the specialty for expert

witnesses in the area of medicine that would typically have the background and experience to give their opinion on such a case.

MINOR PATIENTS: The parent or guardian accompanying a minor child is responsible for payment. We must have pre-approval from a parent or guardian for an unaccompanied minor before treatment can be rendered.

WORKERS COMPENSATION AND AUTO ACCIDENT PATIENTS: We will bill your workers compensation carrier or auto carrier until either your workers compensation claim is denied or your auto benefits are exhausted. If you have private health insurance, we request that you provide that to us when you are initially seen. If you choose not to provide us with your private health insurance, and your workers comp claim is denied or your auto limits are exhausted, you will be personally responsible for any unpaid charges.

I have read the Financial Policy. I understand and agree to this Financial Policy.

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Date: Create Date Long

Signature of Patient or Responsible Party