Joseph J. Furlin, M. D., S. C.

Financial Policy

Thank you for choosing our Obstetrics & Gynecology practice! Please take a few moments to review the following information concerning the payment & billing procedures of the services you will receive in our practice. We have provided this information for you, because ultimately, you are responsible for all charges and payments for services rendered.

We have a billing specialist to assist you with any questions or concerns you may have regarding billing and payments issues.

PROOF OF INSURANCE: It is the responsibility of the patient to provide us with the most up-to-date insurance information and any changes in address, employment, contact phone numbers, etc. Please check with your insurance carrier to insure the physician is a participating member of your medical plan. Please be advised that unreported changes in medical insurance could result in billing delays and errors.

NON-COVERED SERVICES: Please be aware that some or perhaps all of the services you receive may not be covered by your insurance plan in which case you would be responsible for the charges. Please contact your insurance carrier if you have any questions as to which services are covered.

COPAYS AND DEDUCTIBLES: Co-payments and/or deductibles are the responsibility of the patient and will be expected at the time of service. Should you have any questions regarding this service, please ask to speak with the billing specialist. The amount of the deductible and/or copay due at the time of service will be based on our contract with the insurance company or by using a care cost estimator from the insurance company. If we overcharged we agree to refund any difference accurately and timely. Any payment received as a result of billing error will be promptly repaid to the appropriate payer.

SELF-PAY: If you are self-pay the payment in full for the office visit and any laboratory service is due at the time of service. You will be billed for visits and any laboratory service is due at the time of service. You will be billed for visits done without insurance coverage. If you obtain coverage for the dates of service retrospectively then payments for those uncovered services will applied and the previous bills for those dates will be written off. If you present coverage for uncovered visits after the insurance guidelines for proof of timely filing then you will be responsible personally for the dates of service. Ex) Medicaid is 180 days, and other HMO and PPOs are typically 90 days.

PAYMENT METHODS: For your convenience, we accept cash, personal check, and credit cards. A returned check fee of $30 will be added to your account for every check returned for insufficient funs, stopped payment, or closed accounts.

CLAIM SUBMISSION: As a courtesy to you, we will submit a claim for all physician services to your insurance company. Your insurance plan may request information directly from you. Your failure to timely comply with your insurance plan's request may result in your claim denial and if so, you will be responsible for the charges.

PATIENT STATEMENTS: Billing statements will be mailed to patients with insurance coverage after their insurance carrier has made or denied the claim. The statement will reflect all charges not covered by your insurance company and any payments received. Payment is expected within 90 days. If no payment has been received within this time frame, a second statement will be sent. In the event that a third and final statement is required additional collection steps will be taken. If payment is not received at this point you may be discharged from the practice and notification will be made via certified mail.

NO SHOW POLICY: If you miss 3 or more visits without canceling or rescheduling at least 24 hours in advance you may be dismissed from the practice and notification will be made via certified mail.

Thank you for taking the time to read this important information. Again, if you have any questions, please ask to speak with the billing specialist.

I have read the above Josepj J. Furlin, M. D., S. C. Policy and Procedure and agree to abide by its guideline

Patient or Responsible party Name: _____ DOB: _____

_____

Patient or Responsible Party Signature

_____

Date

**** Additional Note:**