Desert Rose Medical Consultants, PC Financial Policy

Thank you for choosing Desert Rose Medical Consultants, PC as your healthcare provider. We are dedicated to providing the best possible care for you. We want you to completely understand our financial policies as it is important to our professional relationship. Please ask if you have any questions. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information etc.)

Please read carefully

PATIENT RESPONSIBILITY:

Your Co-payment, Co-insurance or Deductibles are your responsibility. All patients are expected to present an insurance card at each visit. **All co-payment, co-insurance, deductibles and past balances are due at the time check in.**

If you have deductibles that have not been met then then our policy is to charge $75-150 at the time of the visit. You will be billed for any residual balance as determined by your insurance.

If you are unable to pay your co-payment, co-insurance or deductible, your appointment may be rescheduled unless you have made prior arrangement. **Any amount not paid at the time of service is subject to an additional fee of $25.00 to cover billing cost.** This fee will be waived if payment is made within 5 days. We urge you to help keep our administrative costs down so we can focus on providing quality medical care. Any denial(s) for service(s) not covered under your policy remain your responsibility.

INSURANCE:

1. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a courtesy to you, we will file your insurance claim if you assign the benefits to the doctor. In order to file your claim, we require that you disclose all insurance information including primary and secondary insurance**.** Failure to provide complete insurance information may result in patient responsibility for the entire bill**. Acceptable insurance identification is defined as a valid insurance card. If your insurance company does not pay the practice within a reasonable period of 45 days from the date of billing, we will bill you for payment.** If, we later receive a check from your insurer, we will refund any overpayment to you.

2. Desert Rose Medical Consultants will bill only contracted insurance plans. **If a non-contracted insurance company covers you, full payment is required at the time of service.** We will provide you with an itemized statement. You would need to submit the claim to your insurance company for direct reimbursement to you.

3. Not all insurance plans cover all services; such as vaccines etc. that are deemed necessary by your physician. **In the event your insurance plan determines a service to be "non-covered," you will be responsible for the complete charge.** Payment is due upon receipt of a statement from our office.

MISSED APPOINTMENTS : There will be a charge of $25 for any missed appointment. (All No shows and failure to give at least 24 hrs notice of cancellation/ rescheduling is considered "Missed appointment")

SELFPAY: The full amount is due at the time of service unless payment arrangements are made in advance.

DISHONORED CHECKS: Dishonored checks will be subject to a $25.00 service fee. Dishonored checks not redeemed within 20 days of written notice to the maker will be referred to the County Attorney's office for enforcement of bad check laws. You **will** be placed on a cash only basis following any returned check.

DELINQUENT ACCOUNTS: Delinquent accounts may be assigned to a collection agency or attorney. Additional fees including collection, attorney's fees and interest at 2% per month will be added to the total amount due.

MEDICAL RECORDS: Patients requesting copies of medical records will be charged $35.

OUTSTANDING BALANCE POLICY: It is our office policy that all past due accounts be sent three statements. If payment is not made on this account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs and other additional costs as noted above for delinquent accounts.

RECEIPTS provided to you at time of visit for any payments will be your proof of payment. Please keep these carefully**.**

I, _____ have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature: _____ Date: _____

Name: _____