CareMedica Policies

CANCELLATIONS & NO-SHOW POLICY

When we make your appointment, we are reserving a room for your healthcare needs. If you must change and/or cancel your appointment, please give us 24 hours notice. Your courtesy will make it possible to give your reserved spot to another patient who needs to be seen.

All cancellations and no-shows canceled less than 24 hours notice will be subjected to a $25.00 fee for Routine Office Visits and $50.00 for New Patient Visits, Physicals or Pre-Surgical Exams, and In-Office Procedures. Repeated missed or canceled appointments will result in the loss of future appointment privileges.

The fees are the sole responsibility of the patient and must be paid in full prior to the next appointment.

I, _____, acknowledge the terms of this policy.

VISIT POLICY

ARRIVALS: Please plan to arrive approximately 10 minutes before your scheduled appointment.

ALL PATIENTS upon arrival should bring the following:

- Active Insurance & Prescription Card
- Photo ID
- Current list of medication(s)/and or supplement(s)
- Form of payment for co-payment and/or deductible that is set forth by your insurance carrier
    - *NOTE: CareMedica accepts Cash, MasterCard, Visa, Discover, and American Express*

EXISTING PATIENTS should plan to complete an annual updated registration form, even if there are no changes from the previous year's information.

NEW PATIENTS should be prepared to complete and sign all New Patient Paperwork, including:

- Completed CareMedica Registration Form
- Completed New Patient Medical History Intake Form
- Signed Notice of Privacy Practices Acknowledgement Form (HIPAA)
- Signed CareMedica Policy Form
- Completed Sexual Orientation & Gender Identity Form (SOGI)

****Please Note: If your insurance eligibility cannot be obtained at the time of your appointment, you will be asked to pay for your visit or procedure. If you are not able to pay at the time of service, you will be asked to reschedule*

LATE ARRIVALS: Arriving late for your scheduled appointments may result in having to reschedule your appointment.

PER YOUR INSURANCE: Please note that your insurance carrier may require you to pay an additional copayment and/or deductible for the following:

- Chronic and/or new conditions addressed during an annual physical exam
- EKG, diagnostic in house procedures, and injections

VALUABLES: Please keep your valuables with you at all times during your appointment. We regret that we cannot be held responsible for any lost or stolen items.

AUTO ACCIDENT PATIENTS are required to arrive with the following:

- Auto Policy Declaration page defining the medical provision coverage (Med Pay)
- Date of Accident
- Auto Insurance Carrier Card listing their contact info, and address
- Adjuster's name and contact info
- Claim Number
    - *<u>NOTE</u>: We do not accept Letter of Protection (LOP)*
    - *<u>NOTE</u>: If your policy does not have Med Pay, you will be responsible for paying your copayment and/or deductible set forth in your health insurance policy*

WORKERS COMPENSATION PATIENTS are required to arrive with the following:

- *Name of employer, and their contact information*
    - ****Contact Information includes: Name, Address, and Phone # of the Worker's Compensation insurance company*
- *Date of Injury*
- Adjuster's name and contact info
- Claim Number

<u>NOTE</u>: If your Worker's Compensation claim is denied, our billing office will be your health insurance carrier and you will be responsible for paying your copayment and/or deductible set forth in your health insurance policy as we will.

I, _____, acknowledge the terms of this policy.

PAYMENT/COLLECTION POLICY

We will file a claim to your insurance company; however, all the insurance copayments/coinsurance and/or deductible amounts are due at the time of service. Any outstanding patient balances or uncovered amounts are to be paid prior to being seen. Failure on our part to waive copayments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

Please be aware that some, if not all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You will be billed for these services. If your insurer changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Your insurance policy is a contract between you and your insurance company. It is important that you understand its provisions. We cannot guarantee payment of your claims. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. The practice will send out a maximum of 3 bills. If an account is not paid in full or payment arrangements have not been made, the account will go to collection. Once an account is in collections, it must be paid in full in order to schedule future appointments. There will be no exceptions made.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary changes for our area.

I, _____, acknowledge the terms of this policy.

BILLING CONSENT POLICY

All professional services rendered by CareMedica are the responsibility of the patient set forth by their insurance carrier. If a patient fails to remit payments, disclose proper insurance information and/or does not list a CareMedica provider as their Primary Care Provider; the patient will be sent to collections.

When an account is sent to collections, the patient is responsible for any and all bills, interest and attorney fees incurred.

PLEASE NOTE that if we are not listed as your primary care provider (PCP) with your insurance, it is your responsibility to contact your insurance provider as soon as possible to update and, if necessary, backdate this information. Any claims that are denied must be paid in full.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the rendering Provider and/or CareMedica for my charges.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Physician and/or Caremedica to release any information incurred in the examination and/or treatment to the insurance company in writing, fax and/or e-mail.

MEDICARE STATEMENT (if applicable): Claims will be submitted to Medicare for you by CareMedica. Medicare may not cover some services, which the patient may be responsible for paying if no other supplemental policy exists. Such identified services may include yearly physicals, etc… In addition, you will be responsible for paying for your Annual Medicare Deductible and coinsurance set forth by Medicare. If you have chosen a supplemental policy to Medicare, then your supplemental policy will cover balances based on your coverage.

I, _____, acknowledge the terms of this policy.

Patient Name (printed): _____ Date: _____

Signature: _____